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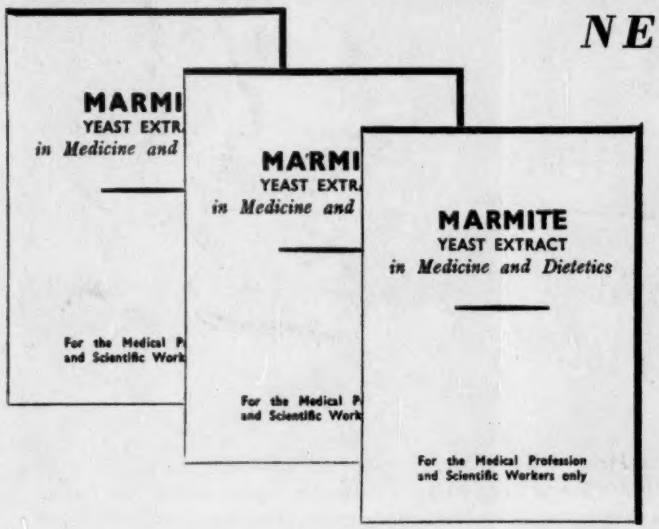

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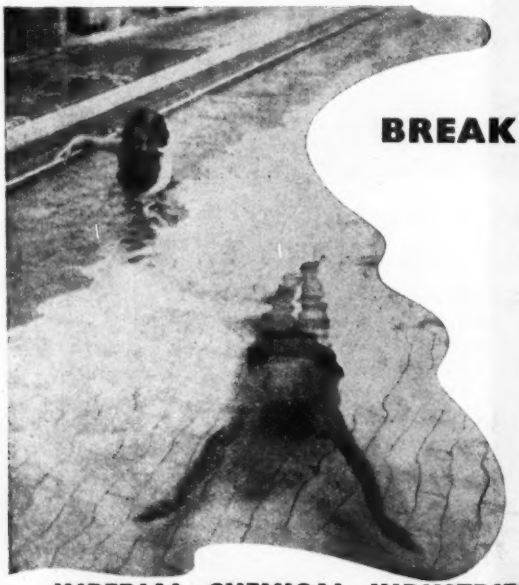

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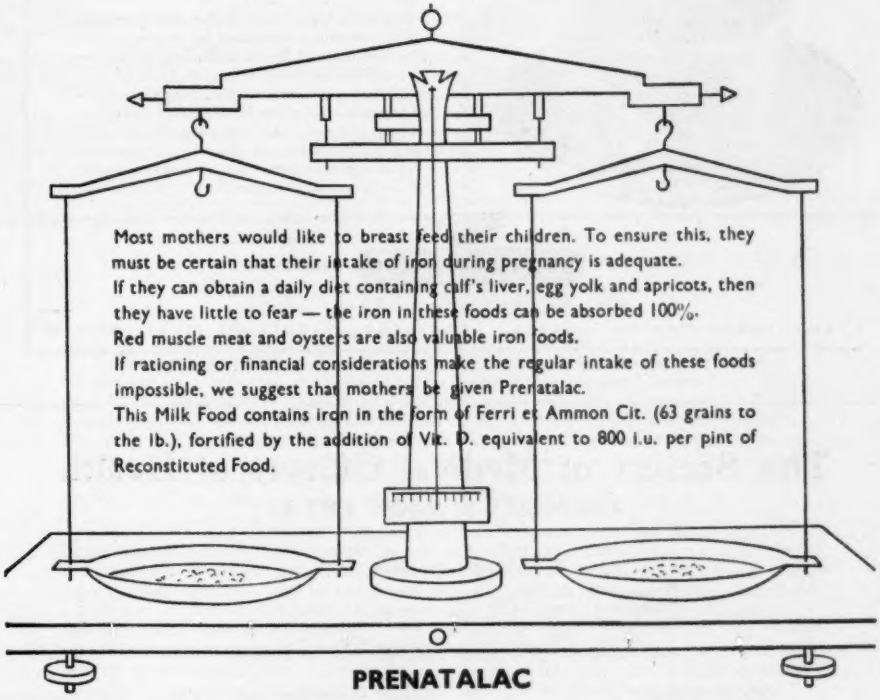

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H.M. KING GEORGE VI

The sudden death of the King on February 6th was felt as a personal loss by each of his subjects, so closely had this unassuming and conscientious monarch entered into all our lives by the circumstances of his reign and by the magic of modern communication, which brought his voice to our firesides and his face to our cinemas, newspapers and magazines. The deep sorrow that is felt at his passing is a tribute to his sterling character and to the virtues in him which the humblest man or woman can emulate ; but the contribution which he made to national unity and to the constitutional value of the Monarchy will, we believe, become more and more apparent as the historians study our troublous period.

The Public Health Service was particularly in sympathy with the late King. As a Royal duke and after he took a particular and sincere interest in the social conditions of our industrial age ; as a man he overcame a physical and nervous handicap which affects many of our school-children ; and he and his beloved widow have given a palpable example of happy married life and of family unity with their children. The King's end came by a coronary thrombosis, the condition which particularly afflicts the man carrying heavy responsibilities and discharging them faithfully. The story of this valiant King may well lead to serious consideration whether the modern State lays too heavy a load on willing shoulders and whether this cannot be somewhat lightened for his heirs and successors.

Our deepest sympathy goes to the Queen Mother, and to Queen Mary, bereft of a dear husband and son, to his daughters, upon the elder of whom devolves the greatest Crown on earth, and to all the members of the Royal Family.

To our new Queen Elizabeth II we humbly offer loyal wishes for a long and successful reign. As a Princess she paid a notable tribute to the Public Health Service on the occasion of the centenary of 1948 and she has shown a personal and continuous interest in maternal and child health as President of the National Association. Her consort, Prince Philip, has been long engaged as a serving officer in the Royal Navy, with its traditional combination of vigilance and discipline with a close regard for the welfare of the lower deck—no bad training for the heavier responsibilities which he now carries. To both these young people we wish many years of health and happiness.

GOD SAVE THE QUEEN!

EDITORIAL

The Ministry of Health's Report, 1949-50

We are glad to know from the reply to a recent question in Parliament that the next report from the Ministry of Health will cover the period April, 1950-December, 1951, and thus get into line with the report of the Chief Medical Officer and cover calendar and not Governmental years; moreover, that the next report will be issued before the end of this year. The Ministry's report (Part I) for the year ended March 31st, 1950*, appeared in December, 1951, three months after the appearance of Part II, "On the State of the Public Health," which we have already reviewed.†

The report now under review covers in its first section the National Health Service (including chapters on International Health and Food and Drugs) and in the second Housing, Local Government, Civil Defence, Welfare and Water. In our comments on the Chief Medical Officer's report, we regretted the disappearance of the sections on maternal and child care and on mental health from that report, but our surmise that they would appear in Part I was correct. Chapters are devoted to these subjects from both the local authority, hospital service and general practitioner viewpoints in the present report. Matters of particular interest under M. & C.W. are the returns regarding premature infants, and references to the survey of heights and weights of young children, the brunt of which will fall on the staffs of selected health departments, and to parentcraft teaching. The mental health chapter has an interesting passage on the problems presented to local health authorities by their new responsibilities in this field. The figures as to the provision of occupation centres and clubs for the training of mental defectives show a rapid increase from 100 centres and four clubs on January 1st, 1948, to 159 centres and seven clubs on January 1st, 1950.

The references to other Part III services are short, and we feel particularly that the report on section 28—prevention of illness, care and after-care—might have been more in accordance with its importance to the N.H.S. as a whole. There will no doubt be much more information under this head available for the next report.

The remainder of the N.H.S. part of the report gives an interesting picture of the early stages of operation of the Service and of the developmental problems which presented themselves, but owing to the lapse of time has a historical rather than a topical interest.

Measuring the Risk of Infection at Work

How few are the known facts about the risk of infection at work. Much of our effort in trying to prevent the spread of pulmonary tuberculosis is directed against "home" infection; to this end it is usual to make many epidemiological enquiries; we rightly examine home contacts with care and regularity. But little attention has been paid to tracing the spread of infection among work-mates (or, for that matter, class-mates in our older school-children). Recently this lack of appreciation of the factory as a focus of infection has been questioned. Laidlaw[1] found that of over 2,800 pulmonary cases in Glasgow only 18% had *ever* lived in the same house with a tuberculosis case of any kind. What are the sources of "non-household" infection?

From the Oxford Institute of Social Medicine now comes the report[2] of an important study made by David Hewitt and Alice Stewart, who find that at least 40% of the cases of tuberculosis occurring amongst workers in Northamptonshire boot and shoe factories during 1940–49 may be attributed to infection at work. For large factories the figure may be as high as 60%. The present study has sprung from the Northamptonshire Miniature Mass Radiography Survey of 1945–46 which is proving to be a mine of knowledge. In 1947 Smith[3] reported a significantly higher proportion of newly discovered cases of active pulmonary tuberculosis among boot and shoe factory workers than among workers in other trades.

Alice Stewart and her colleague, starting from this work, have unearthed the important and unexpected correlation that, during the period 1940–49, there was four times as much tuberculosis in the largest boot and shoe workshops (those with 300 to 400 workers) as there was in the smallest (with 10 to 15 workers and where the incidence was no greater than in the general population), the decisive factor being the distribution of the chronic male carriers who, unless they are detected by mass radiography or other means, may continue working for years, oblivious of the fact that they are a source of danger to others.[4] We must accept the fact that infection outside the home is an important factor in tuberculous morbidity.

Webb and Stewart[5] continued the study of tuberculosis from the point of view of housing. A street survey, in which 3,346 tuberculosis notifications between 1921 and 1948 were investigated, was undertaken. By concentrating on the distribution of cases on the same side of the street it was possible to show that the actual number of cases in next-door pairs of notified houses was significantly greater than the number expected from a chance distribution. They also examined the 600 notifications in boot and shoe factory operatives in the borough and county of Northampton during the decade 1940-49 and "placed" the cases in the individual workshops; in two-thirds of the factories the whole floor area of each room or compartment was obtained; and from this it was possible to measure the floor space per worker. The interesting result was obtained that the maximum risk of tuberculosis appeared to occur in the medium-sized area per worker, and not in the smallest, as might have been expected. Hirch[6] showed that the bacterial contamination in boot and shoe factories was largely determined by the number of persons present whether they worked in small or large compartments or rooms.

Detailed information was also available of the type of work performed by the notified cases.

As a result, there appears cogent evidence that the undiscovered chronic produces most victims; that the largest factory, where the sources of infection are most frequent, is the most dangerous. It is certainly a striking estimate that at least 40% of tuberculosis cases originated in infection at work.

In the past we have been preoccupied with the impression that tuberculosis is passed where there is the intimate relationship of the home, whereas over two-thirds of the tuberculosis cases can be accounted for by reason of contact elsewhere than at the home.

This significant study brings out clearly the importance of mass miniature radiography in an attack on the problem of case finding. In the large factories, where, fortunately, it is comparatively easy and economical to use, mass miniature radiography will produce the most cases. There are many lessons here for the Medical Officer of Health. We may well look in our areas, as Smith so rightly did, to examine the results of the mass miniature radiography service to see if there is any industry which has a higher incidence of tuberculosis. Then, if the area is of manageable size, we might well mark notified cases on a street map to give us information which may lead to the discovery of hitherto unidentified cases and foci of infection. We might well pay more attention to the workshop, for whenever groups of people are gathered together for many hours of the day infection can spread.

Modern industry more and more prefers the larger factory. Here a susceptible young man may meet hundreds of persons daily and hosts of infections, including tubercu-

* Cmd. 8342. H.M. Stationery Office. Price 6s. 6d. net.
† PUBLIC HEALTH (October, 1951). **65**, 1.

[1] LAIDLAW, S. (1949.) Annual Report of the Medical Officer of Health, City of Glasgow, p. 78.
[2] *Brit. J. soc. Med.* (1951.) **5**, 209–222.
[3] SMITH, C. M. (1947.) *Med. Offr.*, **77**, 109.
[4] STEWART, ALICE. (1951.) *Proc. Roy. Soc. Med.*, **45**, 11.
[5] —— & WEBB, JOSEFINE (1951) *Brit. J. soc. Med.*, **5**. 13-33.
[6] HIRCH, A. (1951.) *Brit. J. Industr. Med.*, **8**, 8.

losis, may be passed on. As Hewitt and Stewart say, this phenomenon is well known when civilised and primitive societies meet, but is one which the medical profession is apt to overlook when attempting to explain the prompt rise in the incidence of tuberculosis (and of other infections including infective hepatitis) on the outbreak of war. We may also quote an historical footnote to their paper. During the first half of the 19th century there was an unprecedented migration of country folk into towns, accompanied by explosive outbreaks of many infectious diseases. Since real wages were increasing and food supplies improving during the relevant period, it is impossible to ascribe the outbreaks to a decline in the standard of living. One has, therefore, to conclude that the sudden collision of large numbers of susceptible persons was alone sufficient to cause giant epidemics of diseases such as cholera, typhoid, scarlet fever, and diphtheria, which in their endemic phase have low carrier rates. In this connection it is of interest to note that during the long spell of unemployment in the cotton industry brought about by the American Civil War, the death-rate in several Lancashire towns temporarily declined, as Simon, in 1862, pointed out. Towards the end of the century, when boot and shoe factories began to replace the old cottage workshops, there was undoubtedly an improvement in living and working conditions, yet the excess of tuberculosis in the boot and shoe industry dates from this period (Cairns and Stewart, 1951).

We congratulate all of these investigators who have used the material of a mass miniature radiography survey to such good advantage. The importance of the studies which have followed will have meaning to us far outside the question of the problem of tuberculosis. The field they have tilled is one in which there have been few facts known but from which, if the lessons are learned and followed up, a rich harvest can be gained.

The Cost of Sickness and the Price of Health

Everyone " believes " in preventive medicine, but few are clear on the " reasons for the faith that is in us." Prof. Winslow's monograph* teems with facts and figures and is, therefore, timely. One hundred years ago Chadwick denounced the vicious circle of poverty breeding disease and disease creating poverty. Now Prof. Winslow has some new (and some shocking) circles to describe. Like many American thinkers he takes a global view of health problems. The world cannot happily exist half sick and half well, just as indeed Chadwick's " Sanitary Idea " recognised that our towns could not easily exist half rich, half poor, half sick and half well. Yet to-day over 1,000 million people are burdened with the handicap of poverty and disease. Let us take one example at random—that of Egypt. Prof. Winslow states that the expectancy of life there is only 30 years ; that only 54 out of 100 children ever reach the age of 15, and thus enter productive work. The infant mortality rate in 1948 was 175 per 1,000 live births. The disease of bilharziasis alone reduces productivity by 33% and costs at least 20 million pounds per annum.

In Southern Rhodesia malaria accounts for 5 to 10% loss of the total labour force. In America preventable disease imposes a heavy loss of productive power as well as almost fantastic costs for medical and hospital care.

A National Health survey disclosed that on one day over 4% of the population were so disabled by illness or physical or emotional handicap of some kind as to be unable to go to work.

Deaths from tuberculosis have been reduced to about one-tenth of what they were a century ago ; but Winslow states that the disease still costs the U.S.A. one million years of future working life and 350 million dollars a year for medical and other care.

Our own troubles (which worry and sometimes depress us so much) appear small compared with the arithmetic of disease in other countries. There is another heartening thought that many facts and figures now published in this World Health Organisation booklet prove what we have always preached—the simple fact that the efficiency of workers improves with their better health.

Mosquito-borne diseases in the Philippines commonly caused a school absenteeism rate daily of 40 to 50%, practically all of which was attributable to malaria. Absenteeism has now dropped to approximately 3%. A daily absenteeism of nearly 35% due to malaria among workers caused serious loss of production in 1946—anti-malarial campaign reduced the daily time lost from all causes to less than 4%. In some tropical regions a considerable proportion of the time of the work of the sick peasantry goes into cultivation of food for the intestinal worms which make the worker even more sick.

Throughout the world, wherever one turns, whether in Greece, Italy, Ceylon, Pakistan, or from Thailand to Transvaal, the story is the same. A decisive reduction of malaria case-rates saves life, reduces morbidity, improves child health and raises the living standards. Burma still has over half a million cases. In the Indian peninsula there are over one million deaths per year. This staggering toll of disease gives an indication of the triumphs possible in the future by a wise investment of money, personnel and resources ; but, as we survey the sombre world situation, there appears acute shortages in all these three. Truly, the administrators we need to-day are those who can in the face of present difficulties achieve the maximum of result at the minimum of expense.

We welcome the emphasis placed in this monograph on the promotion of mental health in the public health programme of to-day, the enormous cost of mental illness, and the interference it causes in personal, social and industrial efficiency. The better health education of the public in every country, the training given by " demonstration teams " in backward countries, the contribution which every member of the Public Health Service can make—these form a constructive approach to a vast problem. In this, as in other fields, we should regard the public health nurse as the principal messenger to carry the knowledge of health into the individual home.

Other world-wide problems of to-day include the degenerative diseases, geriatrics and the ageing populations and our old enemy—infectious disease. The annual cost of illness in the U.S.A. is said to reach 38 billion dollars. But here and elsewhere the campaign against diphtheria has saved valuable lives and an immense amount of money. In Detroit a five-year programme for the control of tuberculosis cost $200,000 dollars, but saved nearly a million and a half dollars in sanatoria costs alone. The Metropolitan Life Insurance Company spends over 20 million dollars on health education, early diagnosis and a nursing service among its policy holders, resulting in a financial saving in claims amounting to 43 million dollars. As Herman Biggs stated long ago " public health is purchasable." If mankind wants life, and more abundant life, the comparatively small price must be paid.

Health and Welfare

The advantages of the combined administrative control of public health and social welfare functions of local health authorities under one committee with the Medical Officer of Health as the responsible officer are the subject of frequent discussion in the Society, but information as to the actual position in England and Wales is a little hard to get. The last issue of the *Health Bulletin* (January, 1952, 10, 2), issued by the Chief Medical Officer of the Department of Health for Scotland, describes the position north of the Tweed as follows :—The burghs of Aberdeen and Glasgow and the counties of Fife and Perth have a combined health and welfare committee with the M.O.H. as administrative head ; in Clydebank and Kirkcaldy burghs, Argyll and

* The Cost of Sickness and The Price of Health. C.-E. A. Winslow. World Health Organisation : Monograph Series. Geneva, 1951. London : H.M. Stationery Office. Price 7s. 6d.

Dumfriesshire welfare functions are referred to the health committee and the M.O.H. is administrative head; in Dunfermline and Paisley burghs, East Lothian and Renfrewshire there are separate health and welfare committees, but the M.O.H. is head of both departments; in Port Glasgow burgh, Banffshire and Berwickshire there is a single committee but with separate chief officers. We believe that a recent addition to the combined committee method with M.O.H. as chief officer is Kilmarnock burgh.

Whatever the pros and cons, the above is a good example of the permutations and combinations still possible in the field of British local government even in this age of standardisation.

The London Waters

The Director of Water Examinations of the Metropolitan Water Board holds a unique position in the Public Health Service of this country. He and his deputy, Dr. Windle-Taylor, are, we believe, the only medical men actually concerned in the day-to-day running of a public water supply undertaking. Moreover, the present director, Col. Mackenzie, like his predecessors, is a man of outstanding ability in his special subject with a gift for making this intelligible to non-specialists. Medical Officers of Health with a close interest in, but no direct responsibility for, the purity of water supplies have reason to be grateful for the ever-ready advice and guidance of Col. Mackenzie on the technical aspects of water purity and chlorination, with special reference to risks of water-conveyance of infections.

The appearance of the Director of Water Examination's report for the years 1939–46* could not in any event pass without notice in this journal, but particularly so because this report contains the account of the remarkable efforts by which London's water was protected against the hazards of the war years—an almost incredible achievement when one considers the weight of the aerial bombardment (605 mains were fractured on the night of May 10th–11th, 1941, alone), the size of the water system concerned, the chances of pollution and the enormous population at risk. Even in peace-time it will be recalled that London's water supply is drawn as to five-sixths from rivers running through populous areas, a source of supply which in itself should be suspect but which by skilful and careful treatment is one of the safest in the world before it reaches the domestic tap. For the additional hazards of war a special consultative committee was formed on which several members of this Society, the late Drs. James Ferguson and Maitland Radford, Dr. Thomas Orr, Brig. G. S. Parkinson and Col. Mackenzie himself, served under the chairmanship of Lord Horder. The results of the precautions taken is best shown by the fact that not a single case of water-conveyed typhoid occurred in London as a result of enemy action. The measures actually taken make a fascinating special chapter of the history of World War II.

Col. Mackenzie concludes his account of the war years with a strong warning against a fallacy which was entertained, even in official quarters, that the danger of epidemics from impure waters has been exaggerated, because so many communities "got away with it" in war conditions. He quotes Dr. Arthur Massey, who, as the then M.O.H. of Coventry, wrote of the great raid on his city that "locally we lived on the edge of a volcano for a few weeks following mid-November (1940). No outbreak did, in fact, occur. The escape was due to the immediate application of all preventive measures . . . and also perhaps to a slice of good fortune."

The remaining 40 pages of the report contain a great deal of interesting information on chlorination, control of algal growths, clarification of river-derived supplies and technical matters which may arise in any water supply system. One section, "The Tank in the Roof," has already been printed in the *Medical Officer* of January 12th, 1952 (**87**, 17), as a matter of general public health interest.

* Metropolitan Water Board—34th report on the results of the Bacteriological, Chemical and Biological Examination of the London Waters for the Years 1939–1946. Lt.-Col. E. F. W. Mackenzie, O.B.E., M.C., M.B., D.P.H. (Pp. 102, price 15s. 6d.) Staples Press, Ltd., 14, Great Smith Street, London, S.W.1.

The Purpose of School Medical Inspection

Prof. Moncrieff's suggestion in his 1950 Dawson Williams Lecture to the B.M.A. that periodic medical inspection of school-children had outlived its usefulness, and should be replaced by something on the lines of the Astoria experiment in New York, provoked a very healthy reaction in the School Health Service, which may even have caused the originator to revise his opinion somewhat. A deputation from the Society which was received by Dr. Underwood and others at the Ministry of Education in May last year expressed its view of the value of periodic medical inspection as a preventive measure in no uncertain terms.*

Now one of the champions of periodic inspection, with a wealth of experience to back his opinion, namely, Dr. A. A. E. Newth, Senior School Medical Officer for Nottingham, has returned to the subject in his annual report for 1950, in the following passage :—

"From time to time during the last few years the necessity for these periodic medical inspections has been questioned. It has been said that serious defects in children could be detected by nurses working in collaboration with the teachers in surveys similar to those carried out during the War or perhaps on the lines of the Astoria experiment in New York.

"This may be true, but the detection of serious faults is only one of the functions of periodic inspection—perhaps one of the less important. Ever since they were started in 1908, they have been the only means of assessing the health of the child population of this country and of watching trends of health or ill-health.

"This is of the greatest practical value. But of still greater importance is the bringing together of the parents, the teacher, the nurse and the doctor, to discuss the health of the child. Thus the anxieties of the over-anxious mother may be allayed and the interest of the too casual mother awakened. Faults may be revealed and put right before they get to the stage of being defects. Whenever for any reason there has been an interruption or delay in the periodic medical inspections, teachers and parents have become impatient and have asked for their resumption.

"Great advances have been made during recent years in the treatment of disease and dramatic cures of some previously hopeless conditions have been achieved, but it is clear that it would have been much more satisfactory if these serious conditions could have been prevented or if the stamina of the individual could be built up in childhood so as to help him to resist them.

"The establishment of the National Health Service has not lessened the work of the general practitioner and the specialist in the treatment of disease, and they have less time to devote to prevention than they had 40 years ago when the School Health Service was in its infancy.

"The Local Education Authority in its interest in the intellectual development of the children can never abandon its concern in their physical well-being."

This is one of the hardy perennial questions which arise in the field of public health administration and it is right that it should itself be the subject of periodic re-examination. But, until it is proved beyond doubt to be failing in its objects, we believe that periodic examination of school-children by doctors with a special interest in that work should remain as the chief responsibility of the service.

Variola Minor in Lancashire

There is laboratory confirmation of the diagnosis of variola in a cotton worker resident in Milnrow, Lancs. This woman was unvaccinated. The rash appeared on February 1st, 1952, following onset of fever and constitutional disturbance on January 29th. This patient was removed to a smallpox hospital on February 8th. Her husband sickened on February 14th and developed a rash on February 17th. Her daughter sickened on February 16th and both were removed to hospital on February 17th. Temperatures of 102° F. were recorded during the prodromal stage: thereafter the disease was mild. The rash was discrete and sparse but the distribution typical of variola minor.

It has now emerged that similar cases exist in the adjacent town of Rochdale and the matter is being investigated. 18 cases are now known to have commenced illness during February and 12 during January.

* See report in PUBLIC HEALTH (September, 1951), **64**, 230.

"NO FIXED STANDARDS" *

By COLIN STARKIE, M.D., D.P.H., B.SC.,
Medical Officer of Health, Borough of Kidderminster,
Divisional Medical Officer, Worcestershire

A Presidential Address to such a learned Society as this should be full of very learned material. It should be a very wise and serious dissertation throwing light upon some aspect of our work. Immediately the question arose as to what subject could be discussed which had not already been discussed *ad nauseam*.

Should I read up some special subject? Then either you would be interested and have done the reading-up yourselves, or, on the other hand, you would not be interested and so would not listen to me.

I was still in this stage of wondering what on earth I could bring to you in this Presidential Address that was new, or at least a little different, when one day I had to examine a group of 14-year-old boys. They were about to leave school to become wage earners. I usually ask these youngsters what subject they like in school, and one of them told me he was keen on arithmetic. On examining his teeth I found they had never been cleaned. I told him that unless his teeth were clean he would not get through an interview when he went for a job, and that unless he used a tooth brush regularly his teeth would only last about a third of the time they should. Instead of having them for at least 50 years they would only last for a third of that time. Hoping to impress this firmly on his memory I asked him how long that would be. He had the whole of the examination to work out one-third of 50 but he could not do it. I was rather surprised and asked several youngsters who followed him to tell me what one-third of 50 was, and found that few of them could work out the sum. When discussing this question with the headmaster afterwards, I asked if it would be considered too much for a boy of school-leaving age to work out such a simple sum in his head.

The headmaster's reply was illuminating and called forth the train of thought which I am presenting this afternoon. He said "the trouble is that we have no fixed standards, we don't know what we are aiming at." He also said there were far too many interruptions in school for serious work to be done, and that the boys say they can always get a well-paid job.

It is this idea of "no fixed standards" that is so disturbing. We can all recognise a lowering of standards in general conduct, in morals, in spiritual life, in politics, in general honesty and in international relations. One has only to notice the numerous small acts of discourtesy at the cinema or in a bus to realise what a lack of consideration there is among our fellow-men.

The illegitimacy rate, the thousands of divorces, the flippant way in which many regard the marriage vows, reflect the depreciation of moral standards. Our empty churches and crowded race-courses, the numerous badly cared-for homes and crowded dog tracks give a clue to the spiritual life of the community.

These examples are possibly not the best, but you will all think of many more to support the thesis of our "standards being lowered" or even completely absent. If our standards are debased, then, in order to understand the problem, we must seek the underlying causes. We ask ourselves, "What are these great factors which tend to lower our standards?" and immediately many causes come to mind. Some of these are :—

(1) Fatigue—mental and spiritual—after a long war, and possibly due to type of food.
(2) Dissolving of home and family ties—financial and spiritual.
(3) Loss of the influence of the Churches.
(4) Loosening of the marriage bond.
(5) General depression fostered by Press and radio.
(6) Recurrent national crises.
(7) Threat of international clashes.
(8) Presence of a war which no one knows how to end.
(9) The absorption of human and material resources in preparation for another threatened war.
(10) Threatened famines in the Far East due to inefficient methods of husbandry and to the great increases in population as science succeeds in conquering disease.
(11) Lack of sufficient houses, causing families to be herded together with all the consequent evils.
(12) The doctrine of restrictive practices as applied both individually and collectively.
(13) The numerous and ever-increasing regulations which so obviously invite dishonesty in getting round them.
(14) Lack of stimulating, interesting and lively competition in many fields.
(15) An apparently indefinite and very fluid policy in our educational programme.

You will have your own special list of these causes but mine will suffice here.

The important point is to recognise our position and to do something about it. What can we who are in the field of Preventive Medicine do?

Let us examine the position in some detail.

In our daily round, what are the aims and objects of our professional lives? When we think of the young children the answer is easy. They are under our care from before birth; we know what we want for them—*mens sana in corpore sano* sums it up and we all work constantly for the factors ensuring their health and happiness. At an early age the child comes under the influence of our educational system. First in the infant school. Now what is the aim of the infant school? This seems to vary greatly with the individual H.M.I. and embraces anything from merely allowing them to do just as they please, at one end of the scale, to teaching and guiding them into the rudiments of the three R's at the other. There appear to be almost as many standards as schools. (I nearly said as inspectors!)

And then the primary school. Here the divergence of aim seems even greater. There are some (dare it be mentioned?) whose aim is the passing of an intelligence test at age 10 to 11! There are others who teach numbers, reading and spelling even the hard way, but they have been frowned upon by the august H.M.I., one of whom is stated to have uttered the remarkable dictum that "good spelling is only an inverted form of snobbery"!

Following the primary schools there are in theory two educational streams, but in private there are really three. I refer to the secondary schools, the grammar schools, and the independent schools. From observation and hearsay, the present type of examination qualifying for the grammar school seems to have selected many children who have a certain intellectual smartness, but not necessarily those with enough staying power for an academic career. Many children, the "late developers" and the "conscientious plodders," have been passed over, and excluded for ever, from the type of education both they and their parents desire. Some of these plodders have been sent, at great sacrifice, to independent schools. In the past many of these "late developers" and "conscientious plodders" have provided the backbone of our profession. They were the hard-working, reliable people often with a good home background which gave them very high standards of thought and conduct to inspire them throughout their lives.

We in our profession are very much interested in this trend of events, because we realise that the youngsters of to-day will soon be our colleagues and will be expected to share our responsibilities and to keep up whatever standards we have managed to raise. We must ask ourselves, "Can we state our aims and can we fix our standards?" I maintain that we can and must do both. The key to our

* Presidential Address to the Midland Branch, Society of M.O.H., October 4th, 1951.

problem lies in the idea of discipline. In the first place we need discipline of speech. For hundreds of years our language was clarified by the teaching of Latin and Greek, but this is falling into disfavour and journalese is taking its place—so that we now have the B.B.C. telling us that it will rain " here and there " ; not scattered showers, or rain in some places, but rain " here and there "—a scientific meteorological report !

Such words as " finalisation," " liquidated," " plussage," are in common use, even a " home " is now an " accommodation unit." The distortion of our language has become so serious that H.M. Stationery Office has published a book, " The A.B.C. of Plain Words," by Sir Ernest Gowers, which encourages reports to be written in plain English. The author gives some interesting examples of circumlocution, for instance : " There is a complete lack of ablution facilities " means " There is nowhere to wash." " If they make a nil determination of need " means " If they decide there is no case for giving anything." " Was this the realisation of an anticipated liability ? " means " Did you expect you would have to do this ? "

Of the word " backlog " the only meaning of this known to the dictionaries is a large log of wood forming the back of a fire on the hearth. This is certainly not the meaning it is intended to convey in " A very heavy backlog of orders on the manufacturers' books." Use " arrears " instead.

On the misuse of words, " bottleneck " and " ceiling" are quoted. " Bottleneck " : It is necessary to remember that the most troublesome bottleneck is not the biggest but the smallest. " Ceiling " : One of the bright young metaphors now so fashionable instead of " maximum " or " limit." A typical example quoted of its absurd misuses is : " In determining the floor space, a ceiling of 15,000 square feet should normally be the limit."

The official notice inserted in this book by the Stationery Office describes its object as being to bring home to the Civil Servant " the need for improvement in his use of the instruments with which he works." In other words " to write plain English."

If we can continue the teaching of Latin and Greek and the reading of the Bible we shall maintain a clarity of language which will otherwise be lost. It is up to us, who realise the importance of these things, to press for the retention of our root language in the educational scheme, and then we shall not require Stationery Office publications to tell us how to speak plain English.

Following up the idea of discipline, I wonder if any of you have watched modern school gymnastics. The idea underlying this seems to be relatively slow, graceful, but far from disciplined movements. I cannot help but feel that the straight back, the smart, alert brisk movements as taught 20 years ago had their place in training, and helped to produce alert, disciplined brisk individuals who were the better for their training.

In the field of moral discipline, there is grave slackness. We, the older members of Society, must give both the example and the teaching to the younger generation. It is most important that we should realise the forces against us and as public officials we must actively set out to uphold our standards.

Closely bound up with moral discipline is a sense of responsibility. In our daily routine we see tasks unfinished, letters unanswered, messages forgotten, lack of respect for other people's property. " It isn't mine, therefore it doesn't matter," seems to be the rule. Not only is there an individual lack of responsibility—there is a collective lack also. It pervades every walk of life to some degree ; from the office boy to the senior members of departments. The catch phrases, " I haven't time," " I can't be bothered," " Who cares ? " are used with distressing frequency to cover negligence and irresponsibility. We, in our capacity as public advisers, can help to combat this in our immediate circles of clinic and office and in our wider areas of borough and county.

And in the matter of discipline in hygiene, what do we find ? In spite of years of work, there are still many lousy children, still careless soilers of lavatory walls and seats, still cases of food poisoning, still oral sepsis and still widespread superstition on all aspects of personal hygiene. We have great opportunities in this field which we must take.

Hygiene should be taught first in the home, then in the infant and primary schools, and onwards if necessary to school-leaving age. We teach vocational training. Life is a vocation and the hygiene of living must receive its full status as an essential and compulsory subject.

We are the teachers of hygiene and must spread its gospel farther and more widely than we are doing. We must teach it to the children in schools, to the youth of the country in its clubs and at its work, and must ensure that the future generations know and practise this hygiene for their own health and happiness and for the well-being of more generations yet to come.

Perhaps there may be some among you who think that the subjects mentioned this afternoon are airy and irrelevant, especially when compared with, say, an address on " Public Health Law," or the effects of the National Health Service (with statistics).

However, I would claim this, that what we have been thinking about are the fundamental principles on which our society is built, and although the subject is so vast, yet we must all sometime consider its implications and narrow it down to a practical level from which we can all begin our teaching. If we can only see where things are wrong, and if we all strive each in our own small way to put things right, then we shall surely be making our world a better place.

At this stage of our history it is obvious that we must continue to work as hard as ever we have done and we must encourage others to do likewise. Until many wrongs have been righted there can be no " five-day week " for us.

We must consign to oblivion for ever that devastating and fearful phrase " I couldn't care less," which is so much the hall-mark of our times, and make everyone realise that he (or she) has a great duty to perform in service to others for health and happiness. " We are our brother's keeper." Unlike Cain, we must never forget.

NAPT ESSAY COMPETITION FOR THE P.H.S.

The National Association for the Prevention of Tuberculosis makes the following announcement :—

1. This competition is open to all public health medical officers who, on January 1st, 1952, are working in the Public Health Service in Great Britain.

2. A prize of 100 guineas will be awarded by the Council of the NAPT for an essay judged to be the best of those sent in.

3. The decision of the NAPT Council shall be final, and the right is reserved not to award the prize if, in their opinion, no essay of sufficient merit is submitted.

4. The subject is : " Modern Measures for the Control of Tuberculosis, as practised by Local Health Authorities in Great Britain."

5. The length of the essay shall be proportional to the manner in which the theme is worked out, but regard will be paid more to the merit and originality of the views expressed than to the number of words. As a general guide, 5,000 to 10,000 words, but not more, is considered to be suitable.

6. Essays shall be sent to the Secretary-General, National Association for the Prevention of Tuberculosis, Tavistock House North, Tavistock Square, London, W.C.1, so as to arrive not later than October 1st, 1952.

7. Essays sent in shall become the property of the NAPT, and any of them may be published at its discretion in the author's name.

8. Essays must be submitted under a pseudonym and the name and address of the author given separately.

THE INFLUENCE OF THE ENDOCRINE GLANDS ON THE DEVELOPMENT OF THE CHILD *

By S. LEONARD SIMPSON, M.A., M.D., F.R.C.P.,

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I understand that the members of your Society are interested in normal development of the child between the ages of 5 and 15, and its aberrations. Some years ago it might have been argued by the cynic and sceptic that all this is genetically determined and the endocrine glands play little part and, even when they do, there is precious little that you can do about it. All these statements are neither wrong nor right. They could better be described as incomplete truths or facets of truth but modern knowledge tends to lay greater stress on the importance of the endocrine glands in growth and development and modern therapy offers better prospects of efficacy in the deficiency syndromes, though not to the same extent in those due to hyper-function. Genetic factors are of great primary importance, but we are still interested in the endocrine mechanism by which they operate. For example, genetic strains of dwarf mice show a deficiency of eosinophil cells in the pituitary gland and injections of pituitary growth hormone, which is secreted by the eosinophil cells, will produce augmented growth in these strains. In races which are constitutionally tall, there is a higher proportion of mild acromegalics than in races which are constitutionally short or average.

Inadequate diet, qualitatively or quantitatively inadequate, undoubtedly plays an important part in deficient growth and development as was demonstrated by the unequivocal clinical experiments of Corry Mann (1926) and by studies of war and post-war malnutrition. In some respects the mechanism may be directly metabolic, as was indicated by the tryptophane deficiency experiments of Gowland Hopkins, and in others a vitamin deficiency may operate through the pituitary gland, *e.g.*, vitamin E being necessary for the adequate secretion of pituitary gonadotrophic hormone. Chronic illness such as congenital or acquired heart disease, kidney disease, Von Gierke's glycogen disease, cardiac disease and chronic diarrhoea are some of the many primary non-endocrine causes of deficient development.

However, it is my task to indicate the endocrine aspects and I do so with full conviction as to their importance, not only in skeletal and somatic growth, but also in regard to adiposity, sexual maturation, physical strength, emotional or behaviour patterns, and even intellectual and artistic capacities. Having mentioned non-endocrine causes, I will now assume the right not to refer to them again.

Deficient Growth Rate

In the majority of cases, there is no associated endocrine defect and one can only postulate a single deficiency of pituitary growth hormone genetically determined. Is one justified on a mere hypothesis in attempting endocrine therapy? I am not optimistic in this group that could be labelled idiopathic dwarfism, but where the growth rate is conspicuously retarded I think small doses of thyroid and methyl testosterone are worth a trial. Before withholding such therapy, one must be very careful that one is not dealing with the earliest phases of infantilism or eunuchoidism, because in both these conditions the above therapy, or methyl testosterone alone, may prove very efficacious.

Infantilism was described by Loraine in 1871 and Lévi in 1908, the latter drawing attention to its pituitary origin, with optic atrophy in one of two sisters. The patients are thin graceful types and more often than not there is no obvious pituitary lesion. The radiological bone age is retarded, as is the sexual development. Normal evolution does not occur in the absence of treatment.

With eunuchoidism, there is a primary testicular insufficiency and, as a result, growth is initially retarded but as the epiphyses do not unite until the third decade or later ultimate height may be normal or above normal. Methyl testosterone is very effective in promoting somatic growth.

So effective is testosterone or methyl testosterone in stimulating defective or retarded growth in infantilism or eunuchoidism that, from a clinical therapeutic angle, it might well be called *the* growth hormone. However, its activity is not associated with a raised serum phosphorus as is that of pituitary growth hormone and in animal experiments it does not have a similar chondrotrophic effect on the epiphyseal cartilage. In small animals it may stop growth by causing premature union or disorganisation of the epiphyses but this is not true in man and I do not consider this is a significant consideration in practice. An excessive stimulation or enlargement of the penis is a disadvantage and must be guarded against by intermittent therapy. In girls, enlargement of the clitoris, acne and hirsutism are complications of excessive or prolonged therapy and a resultant croaking of the voice makes me hesitant to use androgens in girls. As to oestrogens, they do appear to be useful both in boys and girls, but by no means consistently and not comparably to androgens. Thyroid sometimes appears to have a synergistic action with methyl testosterone when the latter is not very potent by itself in promoting growth. Of course cretinism and juvenile myxoedema are well recognised causes of retarded growth and thyroid dramatically augments somatic growth in these conditions. It is also effective in some cases of idiopathic retarded growth or in others, where the thyroid deficiency is not obvious or unequivocal. In contrast to thyroid deficiency, thyrotoxicosis in childhood is often associated with augmented skeletal growth. Thyroid accelerates growth rate without augmenting the ultimate height achieved.

As to the pituitary growth hormone, it has now been isolated in pure form from the pituitary gland, free from adrenotrophic, thyrotrophic, gonadotrophic and other substances; and in animal experiments it has a specific chondrotrophic effect at the diaphysial side of the epiphysis as well as a nitrogen retaining action. It restores the defective growth of the hypophysectomised rat and augments growth in normal rats so that giants of three times the normal size are produced. Its action is also associated with a retention of phosphorus and increased serum phosphorus levels. However, clinically it is a very disappointing substance and initial experiments with purified hormone in infantilism and dwarfism have been negative both as to somatic growth and more surprisingly as to nitrogen retention. The matter requires elucidation, but, apart from the inconvenience of painful injections of a foreign protein, pituitary growth hormone has not yet established itself in therapeutics. The subject is also complicated by the fact that Young has recently shown that the pure growth hormone is strongly diabetogenic in the adult cat or dog. However, in the kitten or puppy, that is the growing animal, as in the rat, it is not diabetogenic but growth promoting and nitrogen retaining and it is probable that both these actions are associated with its insulotrophic activity.

Sexual Precocity

Sexual precocity is associated with initial augmented growth, advanced bone age and early union of the epiphyses, so that the ultimate height may be subnormal. These effects are almost certainly due to a hypersecretion of adrenal and or gonadal androgens although there may also be a direct effect of hypersecretion of pituitary growth hormone in some cases. It is of further interest that somatic effects are also noted when the only obvious hormonal cause is excessive oestrogen secretion, *e.g.*, a granulosa cell tumour; but since Moon, Simpson and Evans, of Berkeley University, California, have recently shown that pure growth hormone can produce granulosa cell type changes in the ovary, there may also be here a primary or associated hypersecretion of pituitary growth hormone.

* Address to the School Health Service Group, Society of M.O.H., June 15th, 1951.

If one is faced with a case of sexual or pseudo-sexual precocity, it is necessary to exclude a third ventricle or parapituitary tumour, an interstitial cell testicular tumour, an ovarian tumour, or an adrenal tumour. Hyperfunction of the gonads or adrenals in the absence of neoplasm suggests a primary pituitary or parapituitary lesion. The majority of cases turn out to be idiopathic, that is to say that the primary normal pituitary stimulus of puberty has come into action prematurely without neoplastic cause and both in boys and girls the ultimate evolution may not prove unsatisfactory. Nevertheless, the handling of such cases calls for judgment and discretion and sometimes therapeutic forbearance. Such cases may run in two or more generations.

A New Syndrome—Adipose Gynandrism and Gynism

In 1901, Frohlich, of Vienna, described his syndrome in a boy of 14 with a craniopharyngioma, having the triad of dwarfism (arrested growth), failure of genital development and adiposity, the syndrome being known by his name or as the adiposo-genital syndrome. A similar syndrome was described by the French neurologist, Babinski, in 1900, a girl of 17 also with a craniopharyngioma; and in France the syndrome is known as the Babinski or Babinski-Frohlich syndrome. In both cases the adiposity was moderate and the arrest of sexual development absolute. I wish to emphasise that this syndrome, either in the presence or absence of a craniopharyngioma, is the rarest syndrome in endocrinology.

Since, however, the name of Frohlich's syndrome was applied indiscriminately and inaccurately to fat children, the paediatricians revolted against this error and swung to the other extreme of saying that most adiposity was exogenous and due to gluttony and not endocrine, an equally grave error in the opposite direction, as we shall see. For example, one of the most dramatic manifestations of an adrenal neoplasm in infancy or childhood may be a sudden development of a most voracious appetite and monstrous obesity. Further, Kendall's adrenal compound B may produce a high proportion of fat in relation to protein in the carcass of the experimental animal with actual loss of total body weight and adrenal compound A may have the same effect but with a massive increase in body weight. Thus we must recognise not only that hormones may be the cause of excessive appetite but that qualitative changes of fat-protein proportion may occur in the body as a result of excessive secretion of hormones, with or without total body weight changes in either direction.

Relevant to the above considerations, and because I have always (1938, 1948) taken the view that adiposity was more often than not due to hyperfunction of the pituitary and adrenal glands, I have been able recently to describe a new syndrome in children, called adipose gynandrism in boys because they show a mixture of male and female characteristics and adipose gynism in girls because their feminine qualities are intensified. In addition, both show adiposity of the face and trunk and their height is on the average some 2 inches above the normal, whereas their weight may be twice the normal. The boys often show retarded sexual development although, ultimately, without any treatment they progress to sexual potency and fertility. Their bone age is usually normal but they may continue growing till 21, and they are usually over 6 feet. Their pelvis is wide compared with the shoulders. Secondary sexual characteristics are usually late and they may have scanty hair on the face and trunk in adult life. However, others undergo an androgenic phase in adolescence and may lose their fat and become strong. The girls show an advanced bone age and epiphyseal union may be early, *e.g.*, 13 or 14. Their hips are wide, their breasts large with broad areola of the nipples, and their general appearance may be that of a multipara. Whereas the boys are often somewhat flabby and unathletic, except for swimming, at least until the androgen phase occurs, the girls are strongly built although seldom good runners. They menstruate early and can bear children.

In both sexes, the face is moon shaped and highly coloured. It may be plethoric and cyanotic, as maybe the buttocks and the lower limbs, and the upper arms may show patchy cyanosis. The blood pressure may be raised and even albuminuria and urinary casts may be found. An excess of adrenal glucocorticoids are present in the urine. Polycythamia may be met with. Red or blue lineae distensae (or hypertrophicæ since they may be raised) on the lower abdomen, thighs, buttocks or breasts are nearly always present at one phase of the disorder. It will be gathered that some of the more extreme cases resemble Cushing's syndrome. However classical Cushing's syndrome in childhood is usually associated with defective growth and, experimentally, both cortisone and ACTH have an inhibitory effect on somatic growth. I have therefore postulated an excessive secretim both of the pituitary growth hormone as well as of the pituitary adrenotrophic hormone in adipose gynandrism and gynism, this latter resulting in adrenal cortex hypertrophy and hypersecretion of the adrenal compounds A and E and possibly others. (For fuller description, please see *Proc. Roy. Soc. Med.*, 1951.) Secretion of adrenal androgen may also play a part in augmenting somatic growth and in counteracting the inhibitory action of adrenal glycogen steroids.

As to the ultimate evolution of these patients, they may remain fat or become adipose again after a phase of loss of weight. The men have a greater chance of losing their fat and this is probably due to the inhibition of the excretion of adrenal glycogen steroids by the adrenal and gonadal androgens.

A paediatric complication in childhood and adolescence in the boys is slipping of the head of the femur before union of the epiphyses. This may be bilateral (Simpson, 1951).

Strength and Games

It is recognised that the development of puberty is associated with increased muscular strength in both sexes, and in competitive field games, running, athletics and boxing, etc., there is usually a rough division made into juniors and seniors, the dividing age being perhaps 12 in some schools and 14 in others. This is usually thought of in relation to the maturation of the gonads. It is perhaps not realised that of equal or greater importance is the maturation of the androgenic activity of the adrenal cortex, which occurs in both sexes round about the time of chronological sexual puberty, *e.g.*, 13. The adrenal androgens account for some two-thirds of the total androgenic activity in the male and probably the whole of the androgenic activity in the female, as indicated by the low androgenic content of the urine in Addisons disease and Simmonds's disease. The adrenal androgens are responsible for the pubic and axillary hair of the female and in ovarian agenesis this sexual hair appears at about 13, even though there is no functioning ovarian tissue. Adrenal progesterones are weakly androgenic (Simpson, 1949).

The coming into play of the adrenal androgens was termed by Albright the adrenarche in contrast with the menarche or sexual menstrual puberty of girls. However, it is not generally realised that the adrenarche may precede the menarche or male gonadal puberty (which might be termed testarche) by some years and that its development of intensity may go on for some years after gonadal puberty. In fact, the percentage of males with horizontal pubic hair as distinct from triangular pubic hair decreases considerably in the third decade and there is a corresponding increase in urinary androgens and in strength —hence the greater strength of the mature young man in comparison with the adolescent. Further, the age of onset both of the testarche and the adrenarche varies considerably in boys and as both the testis and the adrenals secrete androgens, and androgens are the most important positive hormone or physiological factor in the determination of muscular strength and prowess, there may be important differences between groups divided according to chronological age and those divided according to hormone age.

Certainly boys of 14 or 16 with delayed puberty cannot compare in strength with those with normal or premature puberty. Similar considerations apply to the adrenarche in girls. These facts are perhaps not sufficiently appreciated by all games masters or gymnastics instructors. The giving of methyl testosterone will increase muscular strength and athletic prowess and in addition to causing growth in height and weight will increase the breadth of the shoulders and muscular development. Its effect, as with other hormones, is greatest when the deficiency is greatest and becomes less marked as we approach normality. Similar effects, but perhaps less striking, are seen with the use of gonadotrophic hormone in boys with delayed sexual maturity.

Turning to endocrinopathies, sexual precocity, particularly when due to an adrenal cortex tumour, or a testicular interstitial cell tumour in boys, is often associated with phenomenal feats of strength and muscular achievements indicating that the adrenal androgens are as potent as the testicular ones in these effects.

There is, however, an adverse effect of the adrenals on muscular strength. Thus, the adrenal glycogen steroids or glucocorticoids, or corticosterones, cause muscular weakness and lack of muscular tone as is evidenced in the patients suffering from adipose gynandrism. Probably several factors contribute to this :—

(1) There is an excessive catabolism of protein and a negative nitrogen balance.

(2) There is a deposition of fat qualitatively in proportion to protein and also quantitatively ; and this fat may be deposited in cardiac as well as skeletal muscle.

(3) There may be an associated negative potassium balance and subnormal values for tissue cell potassium even when serum potassium concentrations are normal.

(4) There may be secondary depression of the secretion of adrenal androgens.

If, however, adrenal androgens are also excreted in excess there may be normal muscular strength and if the androgen secretion predominates, or is alone operative, there may even be supernormal muscular strength, even in the obese individual, subject to cardio-vascular integrity. Apart from actual strength, the obese are mechanically at a disadvantage in most athletic activities except swimming, where they may excel and be aided by the low specific gravity of their total carcass as well as by maintenance of body temperature. I have seen many reports by gymnastics masters abusing fat boys for their apathy, lack of trying and clumsiness in gym classes when the master himself should have been reprimanded for his lack of physiological and psychological understanding. This is particularly unfortunate as these fat boys are often very sensitive to such criticism or strictures, but the task set them is quite beyond their physical capacity. Neither is there any evidence to support the view that their adiposity is due to indolence or lack of exercise, and further, the physical apathy and even somnolence of some fat boys may well be an intrinsic part of their condition. Since it is also true that their excessive appetite is usually determined by their glandular secretions, they seem to suffer from a series of injustices, and are more to be sympathised with and helped by understanding than by recriminations, exhortations or sarcastic condemnations.

I have already indicated that the conception of adrenarche must be extended in time, it being probably spread over several years as the climacteric in relation to the menopause. In some, the androgen adrenarche may be evident as early as eight years of age. The conceptions must also be extended qualitatively to include the adrenal glycogen steroids, and perhaps as yet unisolated more direct fat deposition hormones, although compound A is itself very effective in this direction. The adrenal glycogen steroids, unlike the androgens, are present in appreciable quantities from infancy, particularly if estimated per unit area, but there is a peak at the age of seven or eight and another at 12 or 14. This may be manifested clinically by adiposity at these periods, not only in gross examples of adipose gynandrism, but also in others of lesser degree which merge with normality. The adrenarche, therefore, is androgenic, as Albright indicated, but also glucocorticosteroid, or adiposocorticosteroid, and its range of activity may extend from the age of 7 to 17, with important changes going on all the time but having peaks at 7 and 14 approximately.

Excessive or Rapid Growth

Folk lore and history have many examples of the fabulous strength of giants and more modern studies confirm the fact that giants are often excessively strong as are many acromegalics in their heyday. In later phases, particularly if the disorder is due to a pituitary eosinophil adenoma, weakness sets in and the condition may pass from hyperpituitarism to hypopituitarism.

Apart from obvious endocrinopathies, adults who are made on a massive scale with big shoulders, big hands and feet are usually correspondingly stronger than their more average contemporaries and other things, such as reflex reaction, good eye for a ball, games intelligence, being equal, a "good big one" is better than a "good little one" at most competitive sports. This is evident in the average heights and weights of most sports teams, including even international golf teams, although there are always notable exceptions which do not disprove the rule. Now pituitary growth hormone itself may well be a factor in determining muscular bulk and efficiency, but probably the more important factor is the associated hypertrophy of the adrenal cortex and hypersecretion of adrenal androgens. Cushing himself stressed the great hypertrophy of the adrenal cortex that occurs in gigantism and acromegaly, and although examples of clinical overactivity of growth hormone without associated adrenocorticotrophic hormone can be seen, they are less usual than the close association. The fact that pure growth hormone can be separated chemically from the adrenotrophic hormone is not more important than the great difficulty the chemists originally had in effecting the separation, an indication of the fact that in life physiology they are closely associated.

Turning from adults to adolescents and children, the above considerations hold good. If the growth rate is excessively rapid, or if the secretion of adrenal androgens lags behind the secretion of growth hormone, there may be a phase in which the child or adolescent is less strong and muscular than his contemporaries, hence the homely expression that "he has outgrown his strength." Another factor may be that most of the tissue building has gone into the skeleton rather than into the muscles. There are, however, differences in the strength of the skeleton, some having long thin bones and others long thick sturdy bones. In mild gigantism and/or acromegaly starting around chronological puberty, sexual maturity may be delayed for many years or it may be precocious and intense. The former type are likely to be muscularly weak and the latter strong and to excel at sport. However, some such adolescents are strong without manifesting androgenic hirsutism, even of the face.

Idiopathic sexual precocity is a great factor in the development of strength, whether it is associated with temporary great height, or not, and in its most intense form it leads in boys as well as girls to premature union of the epiphysis, so that the boy does not grow after 12 or so and is shorter than his contemporaries, but nevertheless manifests great strength and ability in games and boxing. The above considerations apply to physiological variations as well as to more definite endocrinopathies.

Both growth hormone and androgens produce increased appetite and the latter is a measure of the needs of the body, so that allowance must be made for these factors in determining the dietetic requirements of different individuals. Further, such hormones result in an increased deposition of protein and not of fat, as does cortisone or ACTH in contrast. This reminds us of the group of tall fat boys who are, nevertheless, not strong and athletic, because another

adverse group of hormones come into play as described in the section on adipose gynandrism.

Emotion and Intellect

Boys suffering from adipose gynandrism, and this constitutes a very large group and not a rare entity, usually manifest some degree of effeminacy emotionalism, sensitivity, and artistic ability, including music. The same is true of girls with adipose gynism. The girls, being girls, untroubled by many of the disadvantages of the boys, are extremely sociable, affectionate and popular. The first part of the song "Nobody loves a fat girl" is far less true than the latter part, "but oh how a fat girl can love." They are extremely gay company, lively and loquacious but they have periods of deep depression. In more technical language, they are cyclothymic. It is relevant that such psychological changes can be produced by the use of cortisone or ACTH. These propensities should be borne in mind by those undertaking vocational guidance so that dull routine jobs should be avoided and anything requiring artistic or creational activities such as music, acting, writing, advertising, promotion, etc., should be encouraged.

From an intellectual point of view, tall fat children tend to have an intelligence quota more parallel with their skeletal than their chronological age so that they do very well at school. This is not necessarily sustained in adult life and early promise must not be relied upon too much in regard to purely intellectual as distinct from imaginative and artistic propensities. Sexual development plays a large part in the formation of character, confidence, judgment, enterprise, initiative, mature intelligence and capacity for sustained study and its early or late development should be taken into consideration in assessing school work and behaviour and formulating term reports, if they are not to be unduly pessimistic or eulogistic. A recent biography on a famous economist shows the tremendous change in his school work and natural leadership that resulted from early sexual maturity and skeletal growth, and in his case, as in many others, the early puberty brilliance was sustained in adult life.

Endocrinopathies and Normality

I have always maintained that major endocrine syndromes are but gross caricatures of minor or incomplete endocrine disorders and that these latter are extremely common and have no sharp dividing line from accepted normality. For these reasons it is important for those dealing with normal development to study major and minor endocrinopathies in order to get a better insight into normal processes, their extremes and aberrations. Neither can an individual be regarded statically ; one should have a dynamic conception of what has gone before and what is likely to come afterwards, bearing in mind that the adrenarche, puberty, adolescence, pregnancy, and the climacteric are important phases of endocrine activity ; also that many endocrinopathies commence in foetal life, or at birth, and proceed to unfold themselves slowly and inexorably, like a Greek drama, throughout the life span, with phases of exacerbation and remission, sometimes terminating, as in the case of Cushing's syndrome described by Achard and Thiers, as late as the age of 71 or so.

Treatment

In general, substitution therapy of endocrine deficiencies is far easier than the inhibition of endocrine overactivity. Delayed sexual maturity can be treated by injecting gonadotrophins, *e.g.*, 500 I.U. intramuscularly twice weekly for six weeks and perhaps repeating after an interval of some months ; or by methyl testosterone 5 mg. once or twice daily over similar periods, by mouth. Gonadotrophins are perhaps preferable if the testes are undescended (but not ectopic) although descent may occur with methyl testosterone. The latter may produce an unduly large penis and erotic behaviour if given in large doses, or over a prolonged period, and cautious control is called for. As far as the undescended testicles are concerned, it is true that the majority will spontaneously descend at puberty but nevertheless pre-puberty treatment may be decided upon for the more general reasons given above. Methyl testosterone is also indicated where muscular development is only slight, or growth is sluggish, even when the evidence of sexual retardation is equivocal. Thyroid may have a synergistic action with methyl testosterone in some cases where each alone is relatively ineffective. Thyroid is specifically called for when thyroid deficiency is obvious or suspected.

Methyl testosterone is indicated where excessive rate of growth is associated with muscular weakness or delayed puberty. Whether methyl testosterone in boys, or oestrogens in girls, can be given in sufficient doses to inhibit excessive secretion of pituitary growth hormone in adolescent gigantism, or mild acromegaly, without themselves being disturbing in their action is not always clear and clinical judgment is called for. Methyl testosterone is certainly helpful in mild acromegaly or gigantism in boys associated with delayed sexual maturity.

As for adipose gynandrism, methyl testosterone is useful for its own biological effects and also probably by inhibiting the excessive secretion of adrenal glycogensteroids but by no means radically or absolutely. I have also found it or testosterone useful when dieting fat adults in so far as it appears to minimise the usual weakness associating with such procedures. However, it may temporarily retard the effectiveness of the dieting and it increases appetite. As for adipose gynism, I know of no way as yet of fundamentally altering this condition. I do not scorn diet, qualitative or quantitative, or appetite depressors such as dexedrine, but knowing their limitations, I must appreciate that in children the most that one can expect is some amelioration and the practical difficulties of application are considerable. It is reasonable to hold out optimistic expectations for the natural favourable evolution of events in adolescence, particularly in boys, and a paediatrician or school medical officer need not be too concerned with the possibilities of adult life, although contact with parents and relatives will not fail to give indications of the future.

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SCHOOL HEALTH SERVICE GROUP

A meeting of the Group will be held at Friends House, Euston Road, London, N.W.1, on Friday, March 28th, at 4 p.m. Dr. D. V. Hubble, consultant paediatrician, Derby, will speak on "Some Aspects of Rheumatism in Children."

COUNTY DISTRICT M.Os.H. GROUP

The annual meeting of the Group will be held at the St. George's Hotel, Margate, on Thursday, April 22nd, at 8.15 p.m. The agenda will be circulated to Group members about the beginning of April.

VITAL STATISTICS, ENGLAND AND WALES, FOURTH QUARTER 1951, AND PROVISIONAL FIGURES FOR THE YEAR 1951

The Registrar General's Weekly Return No. 3, 1952 (H.M. Stationery Office, price 1s.), gives the provisional figures for England and Wales for the fourth quarter of 1951 and for the whole year.

Live Births.—Live births registered in the fourth quarter 1951 numbered 154,212, representing a rate of 14·0 per 1,000 population, compared with 160,200 and 169,302 and rates of 14·5 and 15·3 in the same quarters of 1950 and 1949 respectively. The total of live births registered in the year 1951 was 679,497 being slightly lower than for the year 1950, and representing a rate of 15·5 per 1,000 population compared with 15·8 in 1950.

Stillbirths.—There were 3,807 stillbirths registered in the quarter, giving a rate of 24·1 per 1,000 total live and stillbirths, compared with rates of 22·7 and 22·6 for the fourth quarters of 1950 and 1949 respectively. The annual figure for 1951 (15,949) was lower than those recorded for the years 1950 and 1949 but the rate was slightly higher, being 22·9 compared with 22·7 in the two earlier years.

Deaths.—The deaths registered in the quarter numbered 121,759, representing a rate of 11·0 per 1,000 poulation, compared with 135,359 and a rate of 12·3 for the corresponding quarter of 1950. The total number for the year 1951 was 548,918 and the rate was 12·5 compared with 11·6 in 1950. The increase was concentrated in the first quarter of the year, during which there was a widespread influenza epidemic.

Deaths of children under one year of age in the quarter numbered 4,546, or 28·3 per 1,000 related live births, compared with 5,030 and 5,677, representing rates of 28·3 and 32·3 respectively in the same quarters of 1950 and 1949. The total for the year 1951 was 20,103, representing a rate of 29·6, the lowest ever recorded in this country. This rate compares with 30·0 in 1950 and 52·8 in 1938. In the following table the numbers and rates of live births, stillbirths, deaths and deaths of children under one year of age registered in the December quarter and in the whole year 1951, are compared with the corresponding figures for 1950, 1949 and 1938:—

	Live births		Stillbirths		Deaths (including non-civilians)		Deaths of infants under one year	
	Number	Per 1,000 population	Number	Per 1,000 total live and stillbirths	Number	Per 1,000 population	Number	Per 1,000 related live births
Fourth quarter, 1951	154,212	14·0	3,807	24·1	121,759	11·0	4,546	28·3
" " 1950	160,200	14·5	3,726	22·7	135,359	12·3	5,030	28·3
" " 1949	169,302	15·3	3,917	22·6	128,309	11·6	5,677	32·3
" " 1938	143,756	13·8	5,833	39·0	119,366	11·5	7,504	49·4
Year 1951	679,497	15·5	15,949	22·9	548,918	12·5	20,103	29·6
" 1950	691,760	15·8	16,055	22·7	510,301	11·6	20,817	30·0
" 1949	731,172	16·7	16,977	22·7	510,736	11·7	23,882	32·4
" 1938	621,204	15·1	24,729	38·3	478,996	11·6	32,724	52·8

SOCIETY OF MEDICAL OFFICERS OF HEALTH

NOTICES

MATERNITY AND CHILD WELFARE GROUP

President: Dr. Anna B. Gardiner (Sen. M.O., Kent C.C.).

General Meeting, April 5th

There will be a general meeting of the Group on Saturday, April 5th, at 2.30 p.m., at B.M.A. House, Tavistock Square, London, W.C.1.

Professor A. Leslie Banks, Professor of Human Ecology, Cambridge University, will speak on "The W.H.O. Rockefeller Pilot Study of Workers required to meet Family Health and Welfare Needs."

Clinical Weekend, Oxford, Saturday and Sunday, May 10th and 11th, 1952.

SATURDAY, MAY 10TH

9.30 a.m. *Institute of Social Medicine*

1. Introductory talk on the work of the Institute. The Acting Director—Dr. Alice M. Stewart.
2. Child health survey.
   (*a*) Growth and development.—Dr. J. Parfit.
   (*b*) Illness and nutrition.—Dr. C. Westropp.
   (*c*) Radiological abnormalities in apparently healthy children.—Dr. R. Acheson.
3. Demonstration of Powers-Samas machines.

2 p.m. *The Slade Hospital*

1. Modern trends in the control of infectious Diseases.—Dr. J. P. Warin, M.O.H. Oxford City.
2. Demonstration of cases.

SUNDAY, MAY 11TH

9.30 a.m. *The Radcliffe Infirmary*

1. Retrolental fibroplasia.—Dr. Mary Coxon.
2. The baby with anaemia.—Dr. V. Smallpeice.
3. Demonstration of cases.—Dr. Hugh Ellis.

The Chief Medical Officer, Ministry of Health, has been consulted about the programme for the course, and has stated his view that it should prove of much interest and value to the medical officers who attend it.

REPORTS

COUNCIL MEETING

A meeting of the Council of the Society was held in the Council Room of the B.M.A. on Friday, February 1st, 1952, at 10 a.m.

The Chairman (Sir Allen Daley) presided and there were also present the President (Dr. W. G. Clark), Drs. F. A. Belam, W. H. Bradley, Prof. C. Fraser Brockington, Drs. F. G. Brown, George Buchan, J. S. G. Burnett, H. D. Chalke, Sir John Charles, Drs. T. M. Clayton, H. K. Cowan, Catherine B. Crane, C. K. Cullen, F. M. Day, R. H. G. H. Denham, James Fenton, Miriam Florentin, J. M. Gibson, F. Gray, Kathleen M. Hart, A. S. Hebblethwaite, C. E. Herington, R. H. H. Jolly, J. B. McKinney, J. Maddison, Maurice Mitman, J. B. S. Morgan, A. A. E. Newth, Prof. R. H. Parry, Drs. R. C. M. Pearson, J. A. Stirling, Mr. A. Gordon Taylor, L.D.S., Dr. G. McKim Thomas, Prof. A. Topping, Drs. F. R. Waldron, E. J. Gordon Wallace, W. S. Walton, Nora I. Wattie, Ann Mower White, C. Leonard Williams, H. C. Maurice Williams, and John Yule.

76. **Apologies for absence** were received from Drs. W. Alcock, C. Metcalfe Brown, H. M. Cohen, J. A. Ireland, Hugh Paul, A. G. Reekie, J. Riddell, and Prof. G. S. Wilson.

77. **Welcome to New Member.**—The Chairman extended a welcome to Dr. J. B. McKinney (Northern Ireland Branch), who was making his first attendance at a meeting of the Council.

78. **New Year Honours.**—The Chairman, on behalf of the Council, congratulated Drs. J. M. Gibson and A. A. E. Newth, who were awarded the O.B.E. in the recent Honours List.

79. **Minutes.**—The minutes of the meeting held on November 23rd, 1951 (PUBLIC HEALTH, January, pages 69-72), were confirmed and signed.

80. (*Min.* 6). **Advisory Committee on Research.**—Dr. H. K. Cowan (Chairman) presented a report of the Advisory Committee on Research. The report was adopted subject to the inclusion of the St. John Ambulance Association and the Medical Women's Federation in the list of bodies which were to be informed of the setting up of the Committee ; and with the exception of paragraph 9, Education of the Public concerning Cancer, which was referred back to the Committee for further consideration if they decided that this was a matter which could properly be dealt with under their terms of reference. (*Appendix A.*)

81. (*Min.* 9). **Sanitary Inspectors, Working Party.**—It was reported that the draft memorandum of evidence prepared by Dr. John Maddison had been considered by the Sub-Committee appointed for that purpose. In view of the fact that the Sub-Committee were unable to agree with certain parts of the document and also that it had not been found possible to circulate the memorandum before the meeting, it was resolved to refer the matter to the General Purposes Committee for consideration.

82. (*Min.* 14). **General Practice under the National Health Service.**—A report on the observations of the B.M.A. and the consideration of that report by the special Sub-Committee of the Council was received. Many of the amendments suggested by the B.M.A. were agreed and the Executive Secretary was authorised to forward the amended version of the Society's evidence to the General Practice Committee of the Central Health Services Council. (*Appendix B.*)

83. **Central Midwives Board.**—The statutory instrument amending the constitution of the Central Midwives Board was received. It was noted that the Society was entitled as heretofore to appoint one member of the Board, and it was resolved that Dr. J. M. Gibson be appointed the Society's representative for a period of three years from April 1st, 1952.

84. (*Min.* 59). **Chairman of Council.**—(*a*) A formal letter of resignation from his position as Chairman of the Council, on his retirement from the position of County M.O.H., London, was received from Sir Allen Daley. The resignation was received with regret after Dr. J. M. Gibson had voiced the Council's appreciation of the very great contribution made by Sir Allen to the advancement of public health and in particular of the amount of work which he had done as a member of the Council since 1942 and as Chairman of the Council since 1948.

(*b*) **Election of Chairman.**—On the proposition of Dr. James Fenton, and seconded by Dr. J. Yule, Dr. J. M. Gibson was elected, with acclamation, as Chairman of Council, his period of office to commence on February 19th, the day after Sir Allen Daley's retirement became formally effective.

85. (*Min.* 33). **General Purposes Committee.** (*a*) **Constitution.** It was reported that the President, the Chairman and the Honorary Treasurer had agreed an amended constitution for the General Purposes Committee, as follows :—

1 The President.
1 The Chairman of Council.
1 The Honorary Treasurer.
1 The Chairman of the B.M.A. Public Health Committee (provided he is already a member on the Council of the Society).

From the elected representatives on the Council of the following categories :—

1 County M.O.H.
1 County Borough M.O.H.
1 County District M.O.H.
1 Fever Hospital Medical Service M.O.H.
1 Chest Physician.
1 School Medical Service M.O.
1 Maternity and Child Welfare M.O.
1 Dental Officer.
1 Services Group member.
1 Metropolitan Borough M.O.H.
1 From the representatives of the Scottish Branch.

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The actual persons to be appointed to be decided by the Council as a whole.

(*b*) **Membership of General Purposes Committee.** It was resolved that the following members be appointed the General Purposes Committee for the remainder of the session 1951-52 : Drs. W. G. Clark (President), J. M. Gibson (Chairman of Council), James Fenton (Honorary Treasurer), C. Metcalfe Brown (Chairman of the B.M.A. Public Health Committee)—all *ex officio* ; Drs. H. K. Cowan (C.M.O.H., Essex), W. S. Walton (M.O.H., Newcastle C.B.), J. A. Stirling (M.O.H., Chesterfield M.B.), Maurice Mitman (Fever Hospital M.S.), C. K. Cullen (Chest Physician), A. A. E. Newth (School M.O., Nottingham C.B.), Mirian Florentin (Senior A.M.O., M. & C.W., West Ham C.B.), Mr. A. Gordon Taylor (Dental Officer), Drs. H. D. Chalke (Services), F. M. Day (M.O.H., Hammersmith Met. B.). It was decided not to appoint a representative of the Scottish Branch as a member of the Council during the period of office of the President, Dr. W. G. Clark, who would represent the Scottish Branch for the remainder of the session.

86. (*Min.* 30). **Oral Hygienists.**—It was reported that the Dental Officers Group had no wish to pursue this matter further in view of the fact that the Oral Hygienists Committee had concluded its work.

87. **School Health Service and General Practitioners.**—The report of the Executive Secretary on the arrangements made by School M.O.s with G.P.s regarding the reference of schoolchildren and pre-schoolchildren for specialist investigation, or treatment was referred to the General Purposes Committee for consideration, as also was a recommendation of the East Midland Branch regarding a suggested amendment to the agreement between the Society and the B.M.A. on this question.

88. **Report of the General Purposes Committee.**—Dr. H. C. Maurice Williams presented the report of the General Purposes Committee meeting held on Friday, December 21st, 1951. (*Appendix C.*)

Min. 47. **Whitley Medical Functional Council.**—(*a*) **Implementation.** Dr. A. V. Kelynack, Assistant Secretary, B.M.A., presented a verbal report on the present position regarding the implementation by local authorities of the Awards of the Industrial Court.

(*b*) **Dual Appointments.**—A report on a meeting held on January 22nd, between representatives of the Associations of Local Authorities, the Ministry of Health and the B.M.A., was considered.

The position was that the employers' side and the Ministry had accepted the single contract principle. They had given the B.M.A. the choice of payment on the "major user" basis throughout or fragmentation ; but the latter would have to be accepted for all. The latter would be to the advantage of public health medical officers concerned but to the disadvantage of many chest physicians and other specialists who gave a minor part of their time to the L.H.A.s. Members present considered that they were not in a position to pass any resolution which would bind the appointed representatives of the Public Health Service, and that these representatives should make a decision in the light of discussions which would take place at subsequent meetings to safeguard as far as was possible the interests of the Public Health Service as a whole.

Min. 51. **Royal College of Nursing.**—A report of the meeting of representatives of the College and of the Society was received. (*Appendix D.*) Arising from a paragraph in the report on the subject of health visitors under the N.H.S., it was reported that the Institute of Almoners had set up a committee to prepare evidence for the Scottish Health Services Council on the question of revision of the present Health Visitors Training syllabus and the Institute had requested that a representative of the Society should meet its committee. It was resolved to nominate Dr. Miriam Florentin.

Min. 53. **Leprosy.**—It was reported that a joint deputation of the B.M.A. and the A.M.C. was to interview representatives of the Ministry of Health in the near future.

Min. 60. **Nominations for Honorary Fellowship of the Society.**—It was unanimously resolved that Sir Allen Daley, retiring County M.O.H., London, and retiring Chairman of the Council of the Society ; Dr. James Fenton, M.O., Ministry of Health, formerly M.O.H., Royal Borough of Kensington, Honorary Treasurer of the Society ; Prof. C. E. A. Winslow, Yale, Editor American *Journal of Public Health* ; and Prof. R. D. Defries, Toronto, Editor, Canadian *Journal of Public Health*, be recommended for election as Honorary Fellows of the Society at the Ordinary Meeting of the Society to be held that afternoon.

Min. 61. **Central Health Services Council and Advisory Committees.**—The Executive Secretary was instructed to write to the Ministry formally intimating the retirement of Sir Allen Daley and the appointment of Dr. J. M. Gibson as Chair-

man of the Council. Dr. J. M. Gibson would become an *ex officio* member of the Central Health Services Council.

Min. 67. **Membership of the Society.**—After careful consideration, it was resolved that the names of two candidates be withdrawn from the list of candidates for election at the subsequent Ordinary Meeting of the Society.

Min. 68. **Medical Examination of School Teachers and Entrants to Training Colleges.**—A report of the School Health Service Group on drafts of a circular, administrative memorandum, etc., proposed to be issued by the Ministry of Education, was received and adopted. It was resolved that copies of the report be forwarded to the Ministry of Education and also to the A.M.C. and C.C.A. The following resolution of the Tuberculosis Group Committee was considered :

> " That this Committee views with concern the failure to make specific arrangements for the compulsory *x*-ray examination on entrance to employment, and at specified periods, of school teachers, and requests the Council to press the matter with the Ministry of Education."

And it was resolved to ask the Ministry of Education to introduce an item in the terms and conditions of appointment of teachers so that in future school teachers could be required to submit themselves on entrance to employment and periodically thereafter for *x*-ray examination and that, if possible, existing school teachers should also be required periodically to submit themselves for similar examination.

89. (*Min.* 124/1950). **Functions of the M.O.H.** — The Executive Secretary reported that the probable cost of printing the Society's memorandum on the Functions of the M.O.H. was £175 for 3,000 copies but that there was a possible alternative method of producing a large edition of the document if the Central Council for Health Education installed their own printing machine. It was resolved that the Executive Secretary make such arrangements as he could to have the document printed with as little delay as possible.

90. (*Min.* 37/1951). **Printing of " Public Health."**—It was noted with satisfaction that the printers of the journal were now delivering the issues of the journal in accordance with the agreed schedule.

91. (*Min.* 67/1951). **International Federation of Public Health and Preventive Medicine.**—It was reported that a subscription of three guineas had been forwarded to the Secretary of the Federation. A report on the constitution of the Federation was noted. It appeared that it would be necessary to consult with the other British associations who had been invited to apply for membership to agree on the two British representatives to serve on the permanent committee.

92. **Medical Manpower in War-Time.**—It was reported that the Ministers of Health and Labour and National Service, and the Secretary of State for Scotland, had now decided a scheme for the control of medical manpower. The constitution of the various committees and the procedure for recruitment was noted. It was resolved that Dr. J. M. Gibson, the new Chairman of the Council, be appointed the Society's representative on the Central Recruitment Committee for England and Wales. It was resolved further that the Executive Secretary write to the Honorary Secretaries of Branches asking for nominations for the Area Recruitment Committees as set out in the constitution.

93. (*Min.* 160/1951). **Virus Infections during Pregnancy.**—It was noted that a letter had been circulated by the Ministry of Health to all M.O.Hs. participating in this inquiry and that up to December 31st, 1951, 4,481 pregnancies had been registered from England, Wales and Scotland; of which 788 were virus infection cases (rubella 176, measles 87, chicken-pox 186, mumps 134, polio 25) and 3,693 controls.

94. (*Min.* 206/1951). **Quality Milk Production.** — Members were reminded that on September 21st a memorandum was approved for submission to the Ministry of Agriculture and Fisheries in reply to the Ministry's request for an expression of the Society's views on various problems relating to quality milk production. Following a suggestion of Dr. Magee, and after consultation with Sir William Savage and Dr. Thomas Orr, it was agreed that the following paragraph be forwarded to the Ministry as an addendum to the memorandum :—

> " In any considerations of payments based on chemical composition, we are of opinion that any standards adopted must take into consideration the solids-not-fat content equally with fat content, for both are of nutritional importance."

95. (*Min.* 227/1951). **Medical Record Cards.**—A suggestion from Dr. B. A. Astley Weston on the question of a possible amalgamation of record cards used in the M. & C.W. and School Health Services had been referred to the M. & C.W. and School Health Service Groups. After considering the comments of the Groups, it was agreed that there were many practicable difficulties in having one record card at the moment but that when the standard Home Visiting Card is agreed there should be a joint meeting of the M. & C.W. and School Health Service Groups to discuss further this suggestion. It was felt to be desirable that the relevant information from the M. & C.W. Service should be adapted for transfer to the School Health Service card.

96. **Dentists Bill.**—The Council considered a document prepared by Mr. A. Gordon Taylor, who said that it reflected the views of the Dental Officers Group, and agreed to support the amendments suggested therein. It was also agreed that as a matter of principle all dental inspections should be carried out by Dental Officers who should prescribe any work to be carried out by ancillary workers and that active steps should be taken to press for this principle to be adopted in the Bill. In considering this question the Council had before them a note of comments by the Council of the School Health Service Group and by Mr. K. C. B. Webster, L.D.S.

97. **Public Health (Preservatives in Food) Regulations.** It was reported that a letter dated January 1st from the Ministry of Food invited the Society to forward information relating to the use or proposed use in food of certain substances. The Council had before them the comments of individual members of the Standing Sub-Committee for Food Matters, and it was resolved that these comments be incorporated in a memorandum to be forwarded to the Ministry.

98. **Children's Glasses.**—A letter from the School Health Service Group referred to a memorandum of the Ministry of Health in which it had stated that glasses for children may be supplied in cellon frames on payment of the cost of the frames and in addition 10s. per lens. The School Health Service Group felt that although the cost of the frames should be made by the parents the lenses should be supplied free. After careful consideration the Council decided that it could not support the opinion of the Group.

99. **Pet Animals Act, 1951.**—A letter from the Metropolitan Boroughs Medical Officers Committee referred to the administration of the Pet Animals Act, 1951, and suggested that the R.S.P.C.A., which was believed to have supported the promotion of this Act, might be consulted together with the British Veterinary Association, with a view to establishing uniform standards. It was reported that the R.S.P.C.A. had forwarded a document of recommended standards to the A.M.C. and it was, therefore, agreed that there appeared to be no necessity to take any action for the time being.

100. **Wrapping of Bread.**—A letter from Dr. F. A. Belam (Guildford) drew the attention of the Council to the fact that it appeared that some retailers of bread were interpreting the Statutory Order which permitted purveyors of wrapped and sliced bread to make a reasonable charge in excess of the former maximum permitted additional charge for the wrapping and slicing at the request of the customer, to authorise them to make a charge for the wrapping of unsliced loaves. It was agreed that this was not a matter with which the Society could deal but that it was a matter for local action by the Ministry of Food.

101. **Central Council for Rivers Protection.**—The Council noted with approval a report on the action taken by the Central Council for Rivers Protection in certain of the provisions of the Rivers (Prevention of Pollution) Act, 1951, of which body Dr. W. Alcock and Col. E. F. W. Mackenzie were members on the nomination of the Society.

102. **Membership of Council.**—The Honorary Treasurer gave formal notice that at the May meeting he would recommend that, as a temporary measure of economy, Branches and Groups be asked voluntarily to reduce the number of their representatives on the Council.

103. **Ministry of Education—Medical Inspection Returns of Infestation.**—Dr. J. A. Stirling (Chesterfield) drew attention of members to the fact that the Ministry were asking for information in the medical inspection returns for figures in future years to be given of individual pupils examined in schools in connection with infestation, and for these figures to be further divided under the headings of boys and girls. Dr. Stirling suggested that the carrying out of this request would lead to needless waste of school nurses' time. It was resolved that representations be made to the Ministry of Education accordingly.

104. **Food and Drugs Acts.**—A letter dated January 29th from the Ministry of Food referred to the Society's comments on the proposals for the amendment of the above Acts and gave information of the action which had been taken as a result of the recommendations made. The Council was glad to note that many of the Society's suggestions had been adopted in the draft of the new Bill.

105. **Diphtheria Immunisation.**—A letter from Sir John Charles (C.M.O., Ministry of Health) stated that in view of the present economic circumstances the centrally inspired publicity

campaign encouraging diphtheria immunisation would have to be very limited and asked that M.O.Hs. should press local campaigns with increased and sustained vigour.

106. **Representation of the Society.**—The following were elected :—

(*a*) *Council of the Queen's Institute of District Nursing.*—One representative from May, 1952—Dr. H. C. Maurice Williams.

(*b*) *National Dairymen's Association.*—Annual Conference—Lytham St. Annes, May 12th to 16th. One representative to serve on a panel of experts on the afternoon of May 15th to answer questions—Dr. J. S. G. Burnett.

107. **Recommendations for Fully Paid Life Membership.**—The following recommendations for Life Membership from the East Midland Branch were confirmed for election at the next Ordinary Meeting of the Society :—

Dr. W. Barr, formerly M.O.H., Rotherham C.B. (joined the Society 1911).

Surg.-Capt. A. B. Clark, R.N. (retired), formerly M.O.H., Kirkby-in-Ashfield U.D., and A.M.O., Notts C.C. (joined the Society 1920).

Farewell to Sir Allen Daley

There being no other business, the meeting was declared closed at 12.55 p.m. and members proceeded to the sherry party and buffet luncheon at which the guest of honour was Sir Allen Daley. The President read out letters from members of the Council who were unavoidably unable to be present. On behalf of the Council and of the Society as a whole, he paid tribute to the great influence of Sir Allen Daley during his years of membership of the Society and to the very hard work which he had done both as a member of the Council and in particular during the period of his chairmanship. He wished Sir Allen a long, happy and fruitful retirement and wished him God-speed on his forthcoming trip to America. Supporting speeches were made by Sir John Charles, Drs. George Buchan, James Fenton, T. Ruddock-West, C. Leonard Williams, and J. Yule, and the good wishes of the whole of the members of the Council were conveyed with acclamation.

In reply, Sir Allen thanked the President and all the members of the Council for the compliment which had been paid to him and to his work and thanked the members for the support and help that he had received from them and the staff which had been so helpful to him during his period of office. Sir Alleb wished his successor, Dr. John Gibson, success in the arduous tasks which would now fall upon him, and went on to recall the names of men in the Public Health Service who had been members of the Society and for whose influence on his own career he was very grateful. In concluding, Sir Allen wished the Society continued success and hoped that on his return to this country he would be able again to make some contribution to the work of the Society.

APPENDIX A

Advisory Committee on Research

1. The second meeting of the Committee was held in the Society's Committee Room, Tavistock House South, London, W.C.1, on Friday, December 21st, 1951, at 2 p.m.

2. Dr. J. M. Gibson took the chair at the commencement and welcomed the following co-opted members who were attending for the first time : Dr. W. H. Bradley, Col. A. E. Campbell, Drs. Charles Cockburn, H. M. Cohen, H. Kenneth Cowan, D. D. Reid, and Maurice Mitman. Another co-opted member, Prof. F. Grundy, sent apologies for inability to attend.

3. Other members present were : Dr. H. D. Chalke, Sir Allen Daley, Drs. Miriam Florentin, and H. C. Maurice Williams.

4. **Election of Chairman.**—Dr. J. M. Gibson said that he had accepted the chairmanship for the first meeting only, and he now proposed Dr. H. Kenneth Cowan as chairman. This being seconded and carried unanimously, Dr. Cowan took the chair.

5. **Minutes** of the meeting held on September 20th, 1951, were approved and signed.

6. **Matters arising therefrom**

(*a*) *Inquiry into the Health and Development of Children.*—It was reported that the Society had now received an invitation from the Joint Committee of the Population Investigation Committee and the Institute of Child Health (University of London) to become a joint sponsor of the continuing inquiry into the national sample of children born in one week of March, 1946. The following members of the Society were members of the Joint Committee : Dr. H. M. Cohen, Sir Allen Daley, Prof. I. G. Davies, Drs. Mary Gilchrist, and Jean Mackintosh, and had been asked to act as the Society's representatives also, without any obligation to refer matters back to the Society except those of major policy.

(*b*) *Rubella and other Virus Infections during Pregnancy.*—It was reported that the number of registrations up to mid-October was 3,508, of which 2,730 were control cases and 778 virus infections.

(*c*) *Sonne Dysentery Sub-Committee, M.R.C.*—It was reported that Dr. C. H. Shaw (Deputy M.O.H., Ipswich) had been appointed as the Society's representative on the above, which is studying the mode of spread of sonne dysentery in institutions and generally, and methods of preventing and controlling the disease. It was stated that the L.C.C. and the Metropolitan Boroughs were co-operating in a close study of the incidence and spread of the disease in London.

(*d*) *Poliomyelitis.*—Drs. Bradley and Cockburn outlined the progress made in the national epidemiological and virological investigations during 1951. The former also stated that it was proposed to conduct a pilot inquiry in Essex in 1952 with a view to studying case-to-case conveyance of the infection and the possibility of surveillance as a practical measure.

(*e*) *Breast Feeding and Breast Cancer.*—Dr. Miriam Florentin reported that she had had preliminary discussions with Mr. Hedley Atkins, of Guy's Hospital, on his proposed inquiry into a possible association between human breast milk and development of breast cancer in later life. She had suggested that the inquiry regarding "milkless babies" should avoid arousing any fears which might be damaging to breast feeding.

7. *Post-Injection Paralysis.*—A communication was considered from Dr. Guy Bousfield, who urged the need of a more positive attitude regarding the alleged association of diphtheria/whooping cough immunisation with infantile paralysis. He was convinced that this risk could be overcome by the methods outlined in his lecture at the Wright-Fleming Institute (reported in the *Medical Officer*, June 9th, 1951, page 232). He asked whether some Medical Officers of Health would be prepared to join with him in some practical research on this subject.

He was working on the suppositions (*a*) that diphtheria immunisation by two subcutaneous injections of Holt's P.T.A.P. (0·3 mill.) at a month's interval would be effective and without risk ; (*b*) that a new fluid toxoid prepared by Dr. Holt could be given subcutaneously to young infants of two to five months.

Whilst doubtful whether the number of immunisations so carried out could be great enough to show any conclusions during a period of polio prevalence, the Committee hoped that the publicity given to Dr. Bousfield's ideas through the publication of this minute might put him in contact with M.O.Hs. who would be prepared to co-operate.

8. **Post-Natal Care and Prevention of Cancer of the Cervix.**—Dr. Nora Wattie (Glasgow) had conveyed a suggestion by the Scottish Child Health Group that there might be profitable research into the influence of post-natal care in the prevention of cancer of the cervix. It was agreed to ask Dr. Wattie to elaborate the lines on which such inquiry might be carried out with a view to passing on a proposal to the British Empire Cancer Campaign.

9. **Education of the Public concerning Cancer.**—A draft memorandum prepared by the Central Council for Health Education for the information of local authorities which were considering the possibility of cancer education in order to reduce the delay between first symptom and medical consultation had been referred by the Council to the Committee. The Committee did not feel that it was within their competence to express an opinion on the question of cancer publicity in general, but the view was expressed that education on this subject should be part of a general educational campaign and not the subject of a specialised campaign by public meeting, etc., as suggested in the C.C.H.E. memorandum. From the research point of view, the Committee felt that the effect on mortality from cancer of delays incurred between first symptoms and entry into hospital for treatment was a matter which could only be evaluated by a fully controlled experiment over a period of some years, such as was envisaged in the Manchester area.

10. **Relationship between Domestic Pets and Food Poisoning.**—A letter from Dr. Bradley drew attention to the assumption that dogs in food shops were responsible for contamination of food and the increases in the incidence of food-poisoning. He suggested that Medical Officers of Health might investigate this possibility locally in view of the evidence collected by the P.H.L.S. that salmonellae find a habitat in dogs. He suggested further that the association of domestic pets at home with sporadic cases of food-poisoning deserved closer investigation and referred also to canicola fever.

11. **Audiometric Surveys.**—The Executive Secretary reported that Dr. Hughes (Reading) had inquired in what areas audiometric surveys of schoolchildren were being carried out, and he had replied as to one or two areas and suggested that fuller information might be obtained from Dr. Henderson at the Ministry of Education.

12. **B.C.G. Propaganda.**—The Chairman drew attention to the N.A.P.T. booklets and posters advertising B.C.G. vaccination. He thought that in view of the M.R.C. controlled trials amongst school-leavers in selected areas it was desirable that general propaganda for B.C.G. should be deferred for the time being. The Committee instructed the Executive Secretary to suggest to the N.A.P.T. that their material should be withheld until any risk of vitiating the M.R.C. trials had passed.

13. **Winter Epidemics.**—Dr. Bradley said that the December issue of the Ministry's "Monthly Bulletin" would contain an article under this heading requesting that the earliest possible information be passed to the Ministry about sudden outbreaks of influenza or other respiratory infections and drawing attention to various means of ascertaining their arrival. He thought that opportunities would present themselves for special investigations in co-operation with the Ministry's epidemiological staff. The Executive Secretary undertook to draw the attention of members to this article in the January issue of PUBLIC HEALTH, which would be going to press very shortly.

14. **Gastro-enteritis Outbreaks on Board Ships.**—Dr. Maurice Williams stated that the Association of Port Health Authorities proposed to confer with the Ministry of Transport about the numerous instances of such outbreaks which came to the notice of Port Medical Officers.

15. **Bodies to be Informed of the Purposes of the Society's Committee.**—The Committee approved the following list of bodies which should be informed of the Society's action in setting it up and its objects with a request for co-operation on any matters of common interest :—

Medical Research Council.
Ministry of Health.
Ministry of Education.
Home Office.
Ministry of Food.
Ministry of National Insurance.
Royal College of Surgeons.
Royal College of Physicians.
Royal College of Obstetricians and Gynaecologists.
British Paediatric Association.
British Medical Association.
London School of Hygiene and Tropical Medicine.
Carnegie Trust for U.K.
Nuffield Foundation.
Nuffield Provincial Hospitals Trust.
Rockefeller Foundation.
British Red Cross Society.
Royal College of Nursing.
Queen's Institute of District Nursing.
British Empire Cancer Campaign.
J.T.C.
N.A.P.T.
Empire Rheumatism Council.
Eugenics Society.
Institute of Child Health, London University.
Oxford Institute of Social Medicine.
University Departments of Child Health.
University Departments of Social and Preventive Medicine and Public Health.
Medical Directorates of Navy, Army, R.A.F.

The meeting then adjourned.

APPENDIX B

General Practice and Public Health *

The Society is grateful for the Committee's invitation to give evidence on this important subject. The Public Health Service regards itself as akin to the General Practitioner Service in so far as both are "front line" services and can greatly reduce the expensive burden which falls on the Hospital Service. Under the universal "cover" provided by the National Health Service, the work of public health medical officers and of general practitioners has become complementary rather than competitive, and the old accusation of "encroachment" on private practice by local authority services has lost its meaning. Medical Officers of Health have generally felt that one of the most welcome effects of the introduction of the N.H.S. has been their changed relations and closer contacts with general practitioners. This, together with the increased trend towards prevention in the medical curriculum, makes it all the more desirable that the liaison and co-operation between public health and general practice should be constantly nurtured and strengthened.

In this memorandum we propose to follow in general the order to replies suggested by your Secretary. We will, however, not proffer opinions on matters which are outside our sphere, but only on those in which the work of the general practitioner has obvious connections with that of the public health department.

PART I. Proper Range of Work for a General Practitioner

1A (*e*). *The Practice of Preventive Medicine and Health Education.*

We agree that the general practitioner, with his intimate knowledge of home and family circumstances of his patients, is in a very strong position to advise on measures for the preservation or improvement of health. In our experience, however, the pressure of treatment of minor ailments and of illness, with the present sizes of lists of N.H.S. patients, is so heavy that the general practitioner cannot always give the time required for health education such as that of the mothers of young children carried out in Child Welfare Centres, or of children and parents done by the School Health Service. His should be the strongest influence, backed by the propaganda of the health department, in getting parental acceptance for infant vaccination and immunisation against diphtheria and whooping cough. His aid can be invaluable in keeping the Medical Officer of Health informed of community sickness trends, particularly but not exclusively in connection with the notifiable infections and food-poisonings. (See also under 5 (*b*).)

PART II. Conditions of Practice.

2. *Ancillary Help*

Medical Officers of Health have been anxious to promote schemes for the provision of health centres—the L.H.A.'s responsibility under Section 21 of the 1946 Act—with the object of forwarding the co-operation between the general practitioner and the local authority services. Working in such centres general practitioners would have the advantage of the presence of clerical and medico-social workers (the latter in our view should be health visitors) to carry out their record-keeping and preparation of returns, notifications, etc.

3. *Accommodation and Equipment*

The Society issued a memorandum on Health Centres in 1947 in which G.P. accommodation was suggested on certain lines. It is clear, however, that such details are best considered in the light of local circumstances and in consultation with the local doctors concerned.

4. *Cost of Medicine*

We have no comment to offer.

5. *Liaison with (b) Local Health Authorities*

We have made some preliminary comments under I.A. (*e*) above on the part which can be played by the general practitioner in preventive medicine and health fields which have been developed by the Medical Officer of Health and his staff, but in which the general practitioner should play an increasing part. He has done so in the past when combining his general practice with a part-time engagement as M.O.H. The classical example is that of Dr. W. N. Pickles, of Aysgarth, and his investigation of infective hepatitis (Epidemiology in County Practice (Bristol : John Wright, Ltd., Bristol, 1939)), and it would be difficult to say whether that was carried out in his time as G.P. or as M.O.H.

In regard to the prevention and control of infectious disease, which is the primary duty of the M.O.H., notification by the general practitioner is the principal source of information on which preventive measures may be based. There is an impression amongst Medical Officers of Health that the level of notifications varies widely from one area to another, and we would welcome a reminder to general practitioners of the value to the M.O.H., in carrying out his duties for the protection of the community, of prompt notification, even where diagnosis is not absolutely certain. A recent editorial in *The Medical Officer* (June 9th, 1951) has pointed out that "most of the information which we require to formulate schemes for public health improvement is possessed by the general practitioners, and epidemiology owes more to them than to specialists."

A recent article by Dr. L. R. L. Edwards, Sen. A.M.O., Manchester (in *The British Medical Journal* (May 26th, 1951), 1188) has indicated the extent to which the public health medical officer assists the general practitioner, when called upon, in arriving at a diagnosis of infectious diseases, exclusive of times of major epidemics. Here is a field in which the specialised training of the public health medical officer brings him into active and useful contact with colleagues in general practice. Regarding the general duty laid upon the M.O.H. to keep himself

* *Memorandum of Evidence submitted by the Society of Medical Officers of Health to the Central Health Services Council Committee on General Practice under the National Health Service.*

informed of any matters which may affect the health of his community, he must rely very largely upon the goodwill and vigilance of general practitioners in informing him of an unusual trend in non-notifiable diseases or other conditions. Sir Allen Daley, in the Purvis Oration, 1950 (see *B.M.J.*, June 9th, 1951), has pleaded for "a much closer relationship between the health officer and his staff and those engaged primarily on the curative side," but has also pointed out that "with regard to the individual patients, it is doubtful whether sufficient attention is paid by their medical attendants to inquiry into exactly why they fell ill at that particular time and to the giving of advice on how the patients can, in future, prevent a further breakdown in health." The M.O.H., as a professional health educator, can assist the general practitioner in this respect, for instance, by keeping him supplied with literature on specific conditions such as those prepared by the Central Council for Health Education in connection with the after-care of surgical conditions, etc., or by information of general morbidity trends, by correction of bad environmental conditions and so on.

The *Health Visitor* should be a most important link between the health department and the general practitioner, not only in regard to the health and welfare of mothers and young children, but also in assisting the G.P. in advice to those suffering or having suffered from illness. Cardiff City Health Department pioneered the system by which selected health visitors act as contacts between hospitals, patients after discharge, and their family doctors in respect of special conditions such as diabetes, gastric ulcers and asthma. Newcastle-on-Tyne, in conjunction with the Department of Child Health of the University of Durham, has brought together specialists, family doctors, municipal midwives and health visitors in connection with the home care of premature infants. In general, we consider it to be the business of every M.O.H. to see that his health visitors are personally known to the general practitioners with patients in her district, and to ensure that the health visitor gives no advice which is likely to clash with that given by the family doctor.

Maternity and Child Welfare.—Although no exact figure is available, we believe that the number of general practitioners giving part-time service to L.A.s in the form of sessional duties at ante-natal and child welfare centres runs into many hundreds. It must be said that, whilst Medical Officers of Health are often anxious to bring suitable practitioners into the main stream of preventive medicine by this method, local authorities are apt to discover that it is a more costly way of staffing clinics than is the employment of whole-time assistant medical officers. Suitability of general practitioners for this type of specialised educational work is also important ; and lastly, there must be a clear understanding that once a practitioner has undertaken to conduct a session at a given time, he will not withdraw at the last moment, or arrive late, because of the competing claims of his general practice. Nothing is more damaging to the reputation of a child welfare centre.

The School Health Service.—The general practitioner and the School Medical Officer each has his particular responsibilities for the care of schoolchildren. The general practitioner must provide medical care for children of school age whose names are on his N.H.S. list. In the case of the School Medical Officer, the Education Act, 1944, and the Handicapped Pupils and School Health Service Regulations, 1945, prescribe his duties. The relevant sections of the Act and of the regulations is quoted as their statutory significance are not always appreciated :

Education Act, 1944

Section 48—Medical Inspection and Treatment of Pupils

(1) It shall be the duty of every local education authority to provide for the medical inspection, at appropriate intervals, of pupils in attendance at any school or county college maintained by them, and every local education authority shall have power to provide for such inspection of senior pupils in attendance at any other educational establishment maintained by them.

(2) [Deals withobligation on parents to submit children for inspection.]

(3) It shall be the duty of every local education authority to make such arrangements for securing the provision of free medical treatment for pupils in attendance at any school or county college maintained by them as are necessary for securing that comprehensive facilities for free medical treatment are available to them under this Act or otherwise, and every local education authority shall have power to make such arrangements as aforesaid with respect to senior pupils in attendance at any other educational establishment maintained by them.

(4) It shall be the duty of every local education authority to make arrangements for encouraging and assisting pupils to take advantage of such facilities as aforesaid :

Provided that if the parent of any pupil gives to the authority notice that he objects to the pupil availing himself of any medical treatment provided under this section, the pupil shall not be encouraged or assisted so to do.

Handicapped Pupils and School Health Regulations, 1945
(S.R.&O. No. 1076)

Reg. 43. The Authority shall appoint an officer to be called "the School Medical Officer," who shall be responsible to the Authority for the efficient discharge of their functions in relation to the health and well-being of the pupils who are within the scope of the School Health Service.

As the School Health Service has imposed on it the statutory duty of providing periodic medical inspection of schoolchildren and for the following-up of children found to need supervision or treatment, the School Medical Officer has a legal, ethical and continuing responsibility towards the schoolchildren in his area.

All concerned with the public health regard the School Health Service as fundamental and of the greatest value to the health of the growing generation. It has special commitments in regard to children in whom mental or physical handicaps are affecting education. In the course of periodical medical examinations, the S.M.O. often becomes aware of defects and conditions unknown to the child's G.P., for the reason that parents may not have thought it necessary to consult the latter or may themselves by unaware of the existence of quite serious conditions. The S.M.O. is also particularly on the look-out for visual defects or those of hearing, and for orthopaedic defects, particularly of the feet and spinal column. In this connection the School Medical Officer has always attached great importance to the reference of children suffering from incipient health handicaps for specialist opinion or treatment. In the past many consultants were in the direct service of the L.E.A., to-day such facilities are more usually obtained through the Hospital Service. In cases where reference to a specialist or for hospital treatment is necessary, the following procedure has been agreed between the B.M.A. and the Society in order to avoid any friction between S.M.O. and family doctor concerned :—

(1) Where, in the opinion of a medical officer employed by a Local Authority, a child needs special investigation (other than an ophthalmic examination) or treatment, he should send the child to a specialist only after prior consultation with the child's own doctor, upon whom rests the responsibility for general medical care.

(2) In consulting the general practitioner, the medical officer should give him the opportunity to make the arrangements for the consultation or to agree—by replying or in the absence of a reply—that the arrangements should be made by the medical officer.

(3) A copy of any special report on the child received by the medical officer should be sent to the child's own doctor.

The Society hopes that practitioners will not withhold their consent for such reference to specialist or hospital without good reason. This procedure has been commended to School Medical Officers for an initial period of one year (1951), after which it will be again reviewed by both bodies in the light of experience.

Medical Officers of Health of Local Authorities (who are also School Medical Officers to the L.E.A.) should make a point of keeping general practitioners informed of the special facilities which the School Health Service can make available for handicapped children, *e.g.*, speech therapy, child guidance, physical and remedial training, special residential schooling for delicate and other children. By informing the S.M.O. of all children on their lists who might benefit from those services, general practitioners can enable many children to begin treatment or special education sooner than if they have to wait until referred by a head teacher or by the assistant S.M.O. as a result of periodic medical inspection.

The actual participation of general practitioners in the School Health Service is subject to the same considerations as mentioned above under Maternity and Child Welfare.

Minor Ailments.—Ever since the inception of the School Health Service it has been the practice for school nurses to treat such minor ailments as cuts and sores, skin eruptions and plantar warts, thus relieving pressure on the G.P. and also keeping children under observation with a view to preventing spread of contagions or infections in school.

The Ambulance Service.—The Local Health Authority is statutorily responsible for providing this service and the onus of decision as to its proper use falls upon the M.O.H. Considering the obvious difficulties of deciding upon the propriety of providing transport by ambulance or car in borderline cases, we believe that remarkably little friction has occurred between M.O.H. and G.P. concerned. The increasing demands upon

and cost of this service are an obvious source of anxiety to L.H.A.s and the Exchequer, but we believe that in the public interest the present arrangement should continue.

After-care, Home Nursing, Home Helps.—Under these three heads the M.O.H. can greatly assist the G.P. and lighten his load. Within the limits of woman-power available for nursing and domestic help the Local Health Authorities are endeavouring by good administration to see that such aid is available as required by the general practitioners. The Society has supported a scheme proposed by the Queen's Institute of District Nursing for training enrolled assistant nurses for district duties under the supervision of district nurses.

Greater use might, in our view, be made of sick nursing aids and appliances which L.H.A.s have available for loan.

Care of Inmates of Local Authority Institutions.— It should be noted that the M.O.H. is not necessarily the Local Authority's chief officer in administrative charge of certain L.A. Institutions, such as hostels for deprived children (under the children's officer) or for old people (under the social welfare officer). The M.O.H. is, however, recognised as the medical adviser to all his authority's practitioners engaged on a sessional basis for medical care of these inmates. A difficulty arises where one practitioner is engaged for the general medical and hygienic care of the institution, but others also visit children or old people who, individually, are on various N.H.S. lists ; the G.P. appointed by the L.A. must be informed of such other medical lists.

Care of the Aged at Home.—Here the M.O.H. must work with and assist the general practitioner by good organisation of home nursing and home help, and of ambulance or hospital car service as necessary. The M.O.H. is also well informed of the various voluntary services which help the aged and can put the general practitioner in touch with the appropriate organisations. The standard of local authority and voluntary services for the aged is often now such that the general practitioner will find it in the best interest of such patients to keep them at home and active rather than incur the trouble and delay of getting them into hospital.

Regarding old people who are clearly incapable of staying at home even with nursing and domestic help, the general practitioner in charge can assist the M.O.H. of the district council by giving him full information where the latter should initiate action for compulsory removal to hospital under Section 47, National Assistance Act, 1948, as amended by the National Assistance Act, 1951.

We have dealt above with the relations between the general practitioner and the L.A. clinics for maternity and child welfare, School Health Service, and health visitors and school nurses. The *relation with the domiciliary midwife* may be a more delicate one, since the latter may be attending a woman either as midwife or as maternity nurse, according to whether the general practitioner has been asked to take the case in his charge under the N.H.S.A. or not. In practice, we believe that a good team spirit has been evident, although we are concerned that domiciliary midwives shall not be discouraged by an apparent diminution of the number of cases of which they are in professional charge.

The Chest Clinic.—In this instance the general practitioner should be in the same relation with the chest physician (employed partly by the R.H.B., partly by the L.H.A.) as he was up to 1948 with the tuberculosis officer (then the whole-time officer of the Local Authority). The chest physician welcomes pre-notification consultation by the G.P. which may obviate the unnecessary classification of doubtful cases as tuberculosis. Since 1948 a new preventive duty has fallen upon Local Health Authorities, that of B.C.G. vaccination of contacts of active cases of tuberculosis in the same household. In this connection the early detection of the disease is of particular importance and the vigilance of the general practitioner is of immense value in the control of the spread of the disease. The tuberculosis nurse or health visitor remains the whole-time officer of the L.H.A. and under the guidance of the chest physician should work in close contact with the G.P.

Ante-Natal Clinics.—In general the numbers of expectant mothers attending at L.A. ante-natal clinics have fallen off since the "appointed day." We believe, however, that those clinics should continue not only for the sake of medical supervision of the pregnancy of those who do not wish to book a doctor, but also on account of the educational opportunities for instruction on diet, preparation of clothing and routine examination or urine and blood pressures.

Women who book general practitioners to take charge of their pregnancies and confinements might also be well advised to make use of the educational facilities of the ante-natal clinics.

Opposition amongst general practitioners in some areas to the continuance of L.A. ante-natal clinics has been met by the introduction of regular midwives' clinics which the G.Ps. in charge of cases also attend. This might be extended if G.Ps. could set aside a fixed day each month to meet midwives and patients in the clinics.

5 (*c*) *Relations between the General Practitioner, the Hospitals and the Local Authority.*—Successful co-operation between these three branches of the National Health Service seems to the Society to depend upon willing and efficient exchange of information about cases in which all are interested at one or other stage of the illness of disability. In our evidence to the Central Health Services Council's Special Committee on co-operation, we dealt with this aspect very fully and beg to refer to that document without repeating our previous points. We would say, however, that generally speaking there is better exchange of information between general practitioners and M.O.H.s (and vice versa) than between hospitals and M.O.H.s.

PART III We have no comments to offer under these heads.

PART IV

8. *Maternity Medical Services.*—The M.O.H. is mainly concerned with the question of hospital versus domiciliary confinement, in so far as it affects the provision his authority has to make for domiciliary midwives, maternity outfits and so on. He is also in a position to know, in consultation with the G.P., where hospital confinement is necessary or otherwise on account of home conditions. The Society believes that the trend towards hospital confinement has gone much farther than is justified ; the real reason being the financial inequality on the individual if she stays at home. The cost of hospital confinement from the national point of view is far higher than that of home confinement.

Regarding obstetric committees, Medical Officers of Health of local health authorities are *ex-officio* members. In the opinion of the Society, more general practitioners were originally admitted as G.P. obstetricians than was good for the status of that category of doctors, and the M.O.H. found himself in the invidious position of alienating the G.P. with whom he wished to act in harmony, but the Committees are now beginning to function satisfactorily and the position is, in our opinion, much improved.

10. *Potential and Actual Abuses. The Bottle of Medcine Habit.*—Medical Officers of Health, in the course of their duties as health educators, have found this habit one of the most difficult to eradicate. Local Health Authorities, under the N.H.S. Act, have a general duty to transmit information to the public about the facilities available under all branches of the National Health Service. Some excellent material has been produced in the form of handbooks and leaflets by L.H.A.s. We consider that more might be done in the way of education of the public against abuses of the service, particularly those which fall hard on the G.P. The material would require very careful preparation and consultation between the parties concerned.

APPENDIX C

General Purposes Committee

A meeting of the General Purposes Committee of the Society was held on Friday, December 21st, 1951, at 10 a.m. in the Committee Room of the Society.

The Chairman (Dr. H. C. Maurice Williams) presided and there were also present : The President (Dr. W. G. Clark), Drs. H. D. Chalke, H. Kenneth Cowan, C. K. Cullen, Miriam Florentin, J. M. Gibson, C. E. Herington, R. H. H. Jolly, John Maddison, Maurice Mitman, A. A. E. Newth, Mr. A. Gordon Taylor, L.D.S., and Dr. J. Yule.

Appointment of Chairman.—Dr. H. C. Maurice Williams was appointed Chairman for the meeting.

44. **Apologies for absence** were received from : Drs. C. Metcalfe Brown, George Buchan, James Fenton, Prof. R. H. Parry, and Dr. Hugh Paul.

45. **Minutes.**—The minutes of the meeting held on October 19th, 1951, having been previously circulated, were confirmed and signed.

46. (*Min.* 4). **Reports from Child Guidance Centres.**—The attention of members was drawn to the editorial in December issue of PUBLIC HEALTH, page 39.

47. (*Min.* 5). **Whitley Medical Functional Council.**—(*a*) Dr. A. V. Kelynack (Assistant Secretary, B.M.A.) reported the present position regarding the implementation by Local Authorities of the two Awards of the Industrial Court.

(*b*) *Information regarding Implementation.*—It was reported M.O.H.s had still not forwarded information regarding the implementation of the Awards of the Industrial Court by their Authorities, and the Executive Secretary was asked to take such steps as were necessary to secure that such information was provided to the B.M.A.

(*c*) The attention of members was drawn to the fact that a medical journal had published an advertisement for an Assistant County M.O.H. for an authority which was not fully implementing the Awards of the Industrial Court. It appeared that the

proprietors of the journal were fully aware of the position and that other medical journals would refuse publication. It was resolved that the Executive Secretary be authorised to write a letter of protest to the editor of the periodical concerned.

48. (*Min.* 29). **Durham County Council—Closed Shop.**—Dr. Kelynack informed the members that it was anticipated that the Durham County Council would shortly take steps to satisfy the B.M.A. and the Society on the question of membership of trade unions in respect of the M.O.H.s on its staff.

49. **Mixed Appointment in the Metropolitan Area.**—It was reported that the Public Health Committee of the B.M.A. were taking legal opinion on the terms and conditions of service of the mixed appointment in the Metropolitan area in regard to termination of the appointment and security of tenure.

50. **British Medical Guild.**—The Committee was informed of the result to date of the appeal for contributions to the Public Health Service Defence Trust. It was also reported that grants were being made from the Trust to certain medical officers who had accepted appointments, either wholly, or partly under the control of the Durham County Council, but who had refused to take up their posts until the present dispute was settled, thus supporting, to their own considerable financial disadvantage, the policy of the Society and the B.M.A. It was *resolved to recommend* that a letter be addressed to Branch and Group Secretaries enclosing a draft of a suggested letter which they would be asked to address to individual members calling attention to the need for contributions to the funds of the Public Health Service Defence Trust and asking for renewals of contributions for the present financial year where payments had already been made.

51. (*Min.* 7). **Royal College of Nursing.**—A verbal report was submitted on the matters discussed at a meeting of representatives of the College and representatives of the Society held on December 20th, 1951. A further report will be presented to the Council.

52. **Local Government Act, 1933, Section 111.**—It was *resolved* that copies of the document prepared by the Executive Secretary be forwarded to the County M.O.H. and County District M.O.H. Groups for comment.

53. (*Min.* 15). **Leprosy.**—It was reported that in accordance with the instructions of the Council a letter had been addressed to the Chief M.O., Ministry of Health, asking that further consideration be given to the question of the Leprosy Regulations. The Chief M.O. had been informed that in 1947 the Corporation of Bristol had drawn attention to the ascertainment of a case of leprosy in an active condition by the out-patient department of the Bristol Royal Infirmary and had raised the question of making an order under Section 147 of the Public Health Act, 1936, to make leprosy a notifiable disease within that city, but the Minister had not agreed to this course being taken.

54. (*Min.* 30). **Joint Meeting with the N.A.P.T.**—It was reported that agreement had been reached with the N.A.P.T. for the joint meeting on the subject of "Housing of Tuberculous Families," to be held on February 1st, 1952, at 2.30 p.m., following a brief Ordinary Meeting of the Society. The President (Dr. W. G. Clark) would be in the chair.

55. (*Min.* 38). **B.C.G. Vaccination.**—It was reported that the Ministry of Health had recently issued a letter to Secretaries of R.H.B.s and Boards of Governors asking that information regarding B.C.G. Vaccination of in-patients should be given to the appropriate M.O.H.s of Local Health Authorities. The position regarding out-patients was being investigated.

56. (*Min.* 40). **Cremation Regulations.**—A report was submitted regarding the attendance of representatives of the Society and of the B.M.A. at the Home Office to discuss the proposed new Cremation Regulations. As a result of the interview, the Home Office had undertaken to reconsider the suggestions made in the Departmental Committee's report.

57. **Subsistence Expenses.**—Authority was given for the continued payment to certain members of the Society of expenses which they incurred as representatives of the Public Health Service.

58. **Banking Account.**—Authority was given to the Honorary Treasurer in consultation with the Trustees to take the necessary steps to meet the cash position in the current account.

59. **Chairman of Council.**—Members were informed that Sir Allen Daley had formally intimated his intention to resign as Chairman of the Council of the Society as from February 23rd next. It was *resolved* that the Executive Secretary make arrangements for a sherry party and buffet lunch to be held following the meeting of Council to be held on February 1st and before the Joint Meeting with the N.A.P.T. to be held at 2.30 p.m. on the same day.

60. **Honorary Fellowship of the Society.**—It was *resolved to recommend* that the following persons be nominated as Honorary Fellows of the Society :—

Sir Allen Daley.
Dr. James Fenton.
Prof. C.-E. A. Winslow, Yale (Editor, *American Journal of Public Health*).
Prof. R. D. Defries, Toronto (Editor, *Canadian Journal of Public Health*).

61. **Central Health Services Council and Advisory Committees.**—The Ministry had invited the Society to make suggestions for membership of the C.H.S.C. and certain Advisory Committees. Names to be suggested to the Ministry were agreed as follows :—

(*a*) *Membership of Council*
Dr. C. Metcalfe Brown.
Prof. R. H. Parry.
Dr. H. C. Maurice Williams.
(*b*) *Tuberculosis Advisory Committee.*
Dr. C. K. Cullen.
Dr. H. D. Chalke.
(*c*) *Medical Advisory Committee.*
Dr. H. K. Cowan.
Dr. T. Ruddock-West.
(*d*) *Maternity and Midwifery Advisory Committee.*
Dr. J. M. Gibson.
Dr. Jean Mackintosh.

62. **N.A.P.T. Essay Prize.**—A letter dated November 19th from the N.A.P.T. stated that it was proposed to award a prize of 100 guineas for an essay on "A Brief Survey of Modern Methods for the Control of Tuberculosis as Practised by Local Authorities in Great Britain." It was *resolved* that the N.A.P.T. be informed that the Society was glad to hear of the intention and that they wished to make no observations on the wording of the subject but that the Society felt that the competition should be open to any full-time member of staffs of public health departments.

63. **X-ray Examination of School Teachers.**—The following resolution of the Tuberculous Group was referred to the next meeting of the Council :—

"That this Committee views with concern the failure to make specific arrangements for the compulsory *x*-ray examination on entrance to employment, and at specified periods, of school teachers, and requests the Council to press the matter with the Ministry of Education."

64. **School Building Regulations.**—A letter dated November 20th from the Ministry of Education in reply to the comments of the Society on the draft School Building Regulations was noted.

65. **Decentralisation.**—A memorandum on Divisional Administration forwarded by the County District Group was received. It was *resolved to recommend* that the Council reaffirm its concern with the question of decentralisation and to that end do call a conference of six representatives from each of the County M.O.H. and County District M.O.H. Groups, together with the President, and Drs. J. M. Gibson and H. C. Maurice Willians, the findings of this conference to be accepted by both Groups after confirmation by the Council as the Society's policy.

66. **Public Health (Infectious Diseases) Regulations.**—A letter dated November 29th from the Ministry of Health asked the Society to comment upon the proposal to make new Regulations in substitution of the Public Health (Infectious Diseases) Regulations, 1927. It was *resolved* that the Ministry be informed that the Society considers that Part III of Schedule 4 of the draft Regulations was too linited. It was felt that the heading of Part III be altered to read as follows : "Typhoid fever or other salmonella infections, dysentery, and staphylococcal or any other infection or organism likely to cause food-poisoning," and that the subsequent paragrapha be amended as necessary.

67. **Membership of the Society.**—A letter from the Secretary of the Northern Branch stated that the Branch had now no objection to the nomination for election of two candidates from their area. It was *resolved* that these names be placed on the list of candidates for election at the next Ordinary Meeting of the Society and that full information on each case be available at the meeting of the Council to be held before that election.

68. **Medical Examination of School Teachers.**—A letter dated December 5th from the School Health Service Group on the question of medical examination of school teachers was received. At the request of the Secretary of the Group, and by permission of the Chairman, the letter was withdrawn for further consideration by the Council.

69. **General Dental Services Committee.**—At the request of the Dental Officers Group, the Committee considered, as a matter of policy, a letter dated December 7th from the British Dental Association inviting the D.O. Group to appoint a representative to serve on the newly formed General Dental Services

Committee. It was *resolved* that the D.O. Group be asked to make the necessary nomination.

70. **Refresher Course for M.Os.H.**—It was *resolved* to defer consideration of the question of a refresher course for M.O.H.s for a period of 12 months.

71. **Standing Sub-Committee on Food Matters.**—It was reported that the Standing Sub-Committee on Food Matters were dealing with the following requests from the Ministry of Food :—

(*a*) Labelling of Food Order.
(*b*) Limits for lead in foods.

72. **Relationship between Directors of Education and School Medical Officers.**—A letter dated December 6th from the M.O.H. of a County Borough regarding the relationship between Directors of Education and School M.O.s was received.

73. **Registrar-General—Changes of Address.**—A letter dated December 13th from the Registrar-General regretted that it was not possible to alter the decision not to disclose the addresses of children to M.O.H.s. It was *resolved* that the Registrar-General be asked to receive Dr. J. M. Gibson and the Executive Secretary to discuss the matter further.

74. **Representation of the Society.**

(*a*) *British Council for Rehabilitation.*
Nomination for Executive Committee—Dr. H. C. Maurice Williams.

(*b*) *B.M.A. Tuberculosis Group Committee.*
Co-opted member—Dr. G. W. H. Townsend.

75. **Advertisements in "Public Health."**—It was *resolved* that the Editor of PUBLIC HEALTH be authorised to accept for publication in the journal advertisements from the Scottish Amicable Life Assurance Society in respect of certain policies for which preliminary inquiries would be made to the Executive Secretary of the Society who would be acting as an agent for the assurance society. The policies would be special policies devised by the assurance society to supplement official superannuation schemes and to provide for the payment of school fees for the children of members.

There being no other business, the meeting terminated at 12.30 p.m.

APPENDIX D

Conference with Representatives of the Public Health Section, Royal College of Nursing

The conference took place at the request of the Public Health Section, R.C.N. It was held in the Society's Committee Room on Thursday, December 20th, 1951.

Present. For the Society—Sir Allen Daley, Drs. J. M. Gibson, and H. C. Maurice Williams.
For the R.C.N.—Miss J. M. Calder, Miss Akester, Miss Roberts, and Miss Knight (Secretary, P.H. Section).

Health Visitors under the N.H.S.A., 1946.—The R.C.N. representatives first drew attention to the uncertainty and varieties in interpretations by L.H.A.s, as to the position of health visitors under the Act and Circular 118/47. A specific point mentioned was paragraph 105 of the Central Health Services Council report for 1950, regarding Health Centres which recommended the appointment by L.H.A.s of a socio-medical worker partly as an assistant to the G.P.s working in the centre and partly for the L.H.A.s care and after-care service ; in the view of the R.C.N., this person should undoubtedly be a health visitor. Health visitors were most anxious that the respective spheres of almoners and H.V.s should be further clarified ; this would be especially necessary when health centres were used for consultations with visiting specialists. Encroachment on the H.V.s work by the W.V.S., Voluntary Care Committees, and others was also alleged.

The Society's representatives said they were very much alive to the matters mentioned and the Society would do its best to get the position clarified.

Mental Health Service.—The R.C.N. hoped that the Society would support the view that the H.V., as "the general practitioner of public health," should have a recognised place in the Mental Health Scheme as the front-line worker.

Health Visitors and the Children's Department.—The R.C.N. expressed concern over the lack of co-ordination between their work and that of the children officer's staff. The Society's representatives said that it was our view that the children's department should be under the general direction of the M.O.H., but legislation and the attitude of the Home Office made this unlikely of achievement yet.

Parentcraft Teaching by H.V.s.—The R.C.N. drew attention to the institution by the College of a certificate on the teaching of parentcraft, intended for experienced health visitors, who were asked by education authorities to undertake teaching of parentcraft in schools. The course included lectures and discussions on two nights a week for a period of six months and six to eight half-days during the course on observation and practice teaching. The fees were, for the course 15 guineas (10 guineas for members of R.C.N.) ; for the examination, four guineas.

The Society's representatives asked the College to reconsider the wisdom of granting a special certificate. This would tend to cheapen the basic H.V. certificate course, which was supposed to include adequate instruction on the technique of teaching. They agreed, however, to inform the Society of the existence of this course.

In-Service Training.—The R.C.N. expressed the need for greater local encouragement and aid to health visitors towards keeping up their professional efficiency and interest. They referred to such points as availability of an up-to-date library and current journals, opportunities for meetings, and discussions with colleagues and leave of absence for attendance at conferences and courses.

The Society's representatives were in sympathy with these points but considered that the first steps should be taken locally by approach to the superintendent H.V. or nursing officer, thence to the M.O.H. with specific suggestions.

Confidentiality of H.V.s Reports.—The R.C.N. mentioned one or two instances where confidential information contained in H.V.s reports had been misused by lay officers in health departments. It was agreed that this was highly regrettable and that individual cases of this sort should be reported to the M.O.H. of the department concerned ; but that it was inevitable that confidential information might become known to several persons in a department. A high standard of conduct in this respect must be expected in all staff of a health department if public confidence in it was to be retained.

Superintendents in Welfare Centres.—The R.C.N. drew attention to the recent agreement in the Nurses Whitney Council about the salary scale for superintendents of M. & C.W. Centres. This scale did not allow for the varying responsibilities attached to this post according to the size of the centre. They suggested that one scale should be graded on the following lines :—

Grade I ... Staff up to five.
„ II ... „ six to ten
„ III ... „ 11 upwards.

Our representatives said that the Society had no direct representation on the management side of the Nurses Council but they would give the suggestion publicity in the report of this conference.

Method of Calling in Home Nurses.—The R.C.N. drew attention to an article in *Better Health* by an Area M.O., which had stated that, except in emergency, home nurses could only be called in through a general practitioner. They thought that in fact the usual arrangement was that a home nurse should not attend a case for more than one or two visits without the family doctor's confirmation.

The Society's representatives agreed that in general a home nurse could be called in direct by the patient subject to the above proviso.

ORDINARY MEETING

An Ordinary Meeting of the Society was held in the Great Hall of the B.M.A. on Friday, February 1st, 1952, at 2.30 p.m.

The chair was taken by the President (Dr. W. G. Clark), and approximately 60 members attended.

Minutes.—The Minutes of the Ordinary Meeting of the Society held on December 21st were confirmed.

Honorary Fellowship.—On the nomination of the Council it was unanimously resolved that the following distinguished persons be elected Honorary Fellows of the Society :—

Sir Allen Daley, M.D., F.R.C.P., D.P.H., Chairman of the Society's Council, 1947-1952, retiring County Medical Officer of Health, London. James Fenton, C.B.E., M.D., M.R.C.P., D.P.H., Honorary Treasurer of the Society and a member of the Council of the Society for over 30 years, Medical Officer, Ministry of Health, formerly Medical Officer of Health, Royal Borough of Kensington. C. E. A. Winslow, D.W.P.H., Emeritus Professor of Public Health, Yale University ; Editor, *American Journal of Public Health.* Prof. R. D. Defries, Toronto, Editor, *Canadian Journal of Public Health.*

Life Membership.—The following were elected fully-paid Life Members on the recommendation of the Branches and of the Society :—

Midland Branch.—Dr. E. M. Humpherson (formerly Assistant M.O.H., Birmingham) ; joined the Society 1920. Dr. H. Gibbons Ward (formerly M.O.H., Warwick and Leamington) ; joined the Society 1911. Dr. Janette T. Hill (formerly A.M.O. (M. & C.W.), Birmingham) ; joined the Society 1920. Dr.

W. F. Young (formerly A.C.M.O., Staffs) ; joined the Society 1920.

Southern Branch.—Dr. H. Gordon Smith (formerly M.O.H., Bournemouth C.B.) ; joined the Society 1913.

Election.—The following candidates, having been duly proposed and seconded, were then elected to membership :—

As Fellows.—Carrick, Gordon Staddon, M.B., CH.B. (GLASG.), D.P.H., D.I.H. ; Fraser, Douglas James, M.B., CH.B. (ABERD.), D.P.H. ; Henderson, Ada Margaret, M.B., CH.B. (GLASG.) ; Latimer, Raymond, L.D.S. (BIRM.) ; McDonald, John Corbett, M.D. (LOND.), M.B., B.S., M.R.C.S., L.R.C.P., D.P.H., D.I.H. ; Miller, Mary Swan, B.A., M.B., B.CH. (DUB.), D.P.H. ; Musgrave, Stephen Martin, M.A., M.B., CH.B. (EDIN.), D.P.H. ; Pearse, Edna, M.B., CH.B. (LIVERP.), C.P.H. ; Routley, Paul Edwin Frederick, M.A., B.M., B.CH., D.P.H. (EDIN.) ; Wear, Arthur H., M.D. (DURHAM), D.P.H. ; Williams, Edith Hazel, M.B., B.S. (DUNELM), D.P.H., D.C.H.

As Associate.—Wood, Alfred Andrew, L.D.S., R.C.S. (ENG.).

After nominations for the next election had been reported, the meeting proceeded to the joint discussion with the N.A.P.T. (Full report to be published.)

WELSH BRANCH

President: Dr. W. P. Phillips (Dep. M.O.H., Cardiff C.B.).

Hon. Secretary: Dr. R. T. Bevan (Dep. C.M.O.H., Glamorgan).

A meeting of the Welsh Branch of the Society of Medical Officers of Health was held at B.M.A. House, Cardiff, on October 23rd, 1951. Twenty-two members were present.

Dr. D. E. Parry-Pritchard, the retiring President, thanked the members of the Branch for their support during 1950-51, and welcomed the new President, Dr. W. P. Phillips, installing him with the badge of office.

Dr. Phillips expressed his thanks to the Branch for the honour bestowed upon him and for his Presidential Address he chose as his topic "The Impact of the Health Centre upon the Public Health Service."

Dr. Phillips stressed that the development of public health services was influenced by administrative changes following Acts of Parliament. He pointed out the value of a service which was governed by Councils democratically elected.

The growth of public health was traced. At first its functions were sanitary in nature but these duties were by to-day largely transferred to engineers or surveyors. The School Medical Service and Maternity and Child Welfare had not yet reached their full development.

Dr. Phillips stated that co-operation with the general practitioner had not been so complete as it should have been. The health centre of the future should result in a close relationship between the practitioner and preventive medicine services.

The advantages of the health centre to the general practitioner were enumerated :—

1. A surgery away from his home.
2. Group practice.
3. Better diagnostic and treatment facilities.
4. Nursing assistance.
5. Association of general practitioners and preventive medicine services.

Dr. Phillips concluded his address by giving an account of the design of a health centre planned in the City of Cardiff.

Dr. Scott Thomson proposed and Dr. Anderson seconded a vote of thanks.

A meeting of the Branch was held at B.M.A. House, Cardiff, on November 30th, 1951. There were 14 members and 25 visitors present.

Dr. Powell Phillips welcomed the members of the Institution of Municipal Engineers, pointing out that this was the first occasion when a joint meeting of the societies had been arranged.

Public Health Engineering

Following the confirmation of the minutes of the last Branch meeting the President welcomed the three lecturers from the Rockefeller Foundation.

Dr. Logan was the first speaker and he confined his remarks to the American point of view of public health engineering. He said that the genius of Europeans was their originality of ideas whereas the American genius was in the adapting of ideas. He outlined the administration in America and stressed the importance of team work—the engineer, the doctor, the bacteriologist, the statistician formed some of the team. In America this co-ordination of experts had been very successful. He gave examples to show how by this means a high standard of health and comfort had been obtained for the population.

Mr. Bruce dealt with the training of public health engineers. He said that in the past the training had been inadequate but that it was hoped that the course now in existence at the Imperial College of Science and the London School of Hygiene and Tropical Medicine would at least in part rectify the position. The course consists of three parts: (1) Fundamental sciences; (2) Application of the principles; (3) Joint lecturers with D.P.H. students at the London School of Hygiene and Tropical Medicine. The whole course covered a year of post-graduate study.

Dr. Guymer illustrated the importance of preventive medicine in wars. He stressed the importance of team work between the doctor and engineer and showed that such team work had frequently made uninhabitable areas safe centres of population. In his opinion doctors had insufficient knowledge of engineering and he thought this was particularly so in the field of Industrial Health. Occupational diseases could be overcome only if doctors understood the industrial processes involved.

There followed a very lively discussion, a feature of which was the criticism of the post-war syllabus for the Diploma in Public Health. Some members were of the opinion that new entrants to public health would know even less about the engineering side of sanitation than their predecessors. The engineers, on their part, were convinced that team work was the answer to many of the existing problems.

Mr. Roberts (Cardiff City Engineer) proposed and Dr. Colston Williams seconded the vote of thanks to the speakers.

A meeting of the Branch was held at B.M.A. House, Cardiff, on January 11th, 1952. There were 20 members and 33 visitors present.

Minutes of the previous Branch meeting were read and approved and the Treasurer's Report for the year 1950-51 was received.

Prof. Grundy introduced Mr. Roberts, medical student of the Welsh National School of Medicine, who had been recommended for the Hygiene Prize for the year 1951. The President presented Mr. Roberts with the books which he had selected as the prize.

Prof. J. M. Mackintosh then addressed the Branch choosing as his subject "The Half Century."

Dr. Culley proposed and Dr. Greenwood Wilson seconded the vote of thanks to the speaker.

WEST OF ENGLAND BRANCH

President: Dr. A. M. McCall (M.O.H., Chard, Ilminster, etc., A.C.M.O., Somerset).

Hon. Secretary: Dr. R. H. G. H. Denham (M.O.H., Bathavon, Frome, etc., A.C.M.O., Gloucestershire).

A meeting of the West of England Branch of the Society was held in Shire Hall, Taunton, on November 3rd, 1951. The President and nine members were present.

After thanking members and officers for their support during the year the retiring President, Dr. Cormack, installed Dr. McCall as President for the ensuing year and invested him with the presidential badge of office.

The President read a paper entitled "The Atom Strikes," in which he gave a brief summary of the present knowledge of nuclear physics and an account of the effects of atomic explosion on buildings and the human body. He proceeded to outline the known methods of protection and decontamination of both persons and various types of foodstuffs. The paper was much appreciated by members present both for the information it contained and for the amount of research and enquiry that the President had evidently made. (It will be published in full in PUBLIC HEALTH.)

A vote of thanks to the President for his interesting address was proposed by Dr. Morris-Jones and seconded by Dr. Cookson.

NORTH-WESTERN S.H.S. & M. & C.W. SUB-GROUPS

President: Dr. Gladys Wilkinson (A.S.M.O., Cheshire).

Hon. Secretary: Dr. E. M. Jenkins (Sen. M.O., S.H.S., Manchester C.B.).

The second meeting of the Groups for the 1951-52 session took place in the Public Health Committee Room, 3rd Floor, Town Hall Extension, Manchester, on November 23rd, at 5 p.m. Sixteen members were present.

Amongst the few matters referred to under the "business arising" from the minutes were the questions of printing the Presidential Address and renaming the North-Western Joint Sub-Groups. The President stated that she was still of the opinion that her address was not intended for publication.

Dr. Janus was then briefly introduced to the meeting by the President, and there followed his most interesting and illuminating talk. He gave a short history of a survey conducted at Leigh into the percentage of the population who had had or thought they had had symptoms of rheumatic origin during

their lifetime. It was obvious that rheumatic-like pains were common but could be due to a variety of causes having no relation to rheumatism proper. Then followed the story of the pathogenesis of rheumatoid arthritis, and the effects of cortisone injections on the symptomatology and progress of the disease.

The talk was profusely illustrated by excellent slides and concluded with a film showing an actual patient with arthritis before, during and after treatment with cortisone.

Dr. Janus has kindly provided a précis as follows:—

1. This collogen disease differs from other diseases in that the primary change is a chemical one, occurring in connective tissue.

2. It is the cellular response to the primary change that is responsible for the signs and symptoms of rheumatoid arthritis.

3. The cellular response can be blocked by using cortisone, and clinical evidence of disease thereby suppressed. This treatment is rational and useful if the original disease process is one likely to remit spontaneously, in that it prevents cellular damage and therefore permanent structural damage.

4. The risk of blocking the cellular response with cortisone is that it also blocks the response when it is a necessary protection to the body, and in infections, wounds and ulcers.

5. Before using therapy it is necessary to weigh these considerations carefully in the balance. If not judiciously used in this way, these substances (ACTH and cortisone) are likely to do more harm than good.

A vote of thanks to the speaker was proposed by Dr. Kane, who said Dr. Janus had brought back pleasant reminiscences to her of student days and splitting of proteins, and how much she was sure everybody had enjoyed the lecture. Her vote of thanks was supported most warmly.

SCHOOL HEALTH SERVICE GROUP

President: Dr. A. Morrison (Sen. S.M.O., Derby C.B.).
Hon. Secretary: Dr. A. A. E. Newth (Sen. S.M.O., Nottingham C.B.).
Hon. Asst. Secretary: Dr. J. B. S. Morgan (C.M.O.H., S.M.O., Derbyshire).

An ordinary meeting of the Group was held in the Old Library, B.M.A. House, London, on October 19th, 1951. Forty-five members were present.

After the apologies for absence had been read, the Acting President, Dr. G. H. Hogben, in the absence of the retiring President, Dr. F. J. G. Lishman, invested Dr. Morrison with the Presidential Badge. He recalled that Dr. Morrison was one of the original members of the Group since its revival, the first meeting being held in the Guildhall, Derby, on December 3rd, 1943, and had given most generously of his services to the Group, having been Assistant Hon. Secretary since then, except for the session 1949-50 when he was Hon. Secretary. Dr. Morrison, after thanking the Group for the honour they had conferred on him, spoke of his predecessors whose names were engraved on the bars of the ribbon of the badge he was wearing.

The President then signed the minutes of the previous ordinary meeting held on March 30th, 1951.

The Hon. Secretary reported that the Council had met on June 15th and on that day. Among other matters dealt with had been the Draft Tuberculosis Regulations, Draft School Building Regulations. Medical Record Cards, and the question of the age at which children should enter school and the education of backward children in ordinary schools, and co-operation between chest clinics and L.E.A.s. They had decided to repeat the Manchester Refresher Course on Deafness in the spring of 1952. They had formulated replies to the questions on child guidance put to the Society by the Secretary of the Committee of the Ministry on Maladjusted Children and had nominated members to give oral evidence.

They had decided that ordinary meetings should be held on January 18th an dMarch 28th, 1952, and the annual general meeting on June 20th, 1952. Drs. Cheesman, Gilchrist and Hogben were appointed to serve on the Inter-Group Committee.

The following Fellows of the Society were unanimously elected as members of the Group: Drs. F. G. A. Armson, A. M. Brown, June B. Brown, Lily C. Butler, A. S. Carey, Edna Circuitt, Gwendolen K. G. Coote, D. M. Evans, A. A. Ford, G. Fraser-Smith, F. V. Jacques, Dorothy M. Jones, Mary A. H. Lawson, Martha E. Lebermann, Joan N. Leedham, Hilda M. Levis, J. W. McConachie, W. H. S. McGregor, Brenda M. Mead, Margaret M. Meikle, E. S. A. Meyers (N.S.W.), Enid A. Reed, O. V. Rees, L. S. Stephens, Alta F. Stout, S. W. W. Terry, W. Wagland and G. E. Welch.

Dr. Morrison then read his Presidential Address, which has been published in PUBLIC HEALTH, December, 1951. After a most interesting discussion, the appreciation of the meeting was expressed by Dr. Hogben seconded by Dr Alford.

OBITUARY

Sir RALPH BIGNELL AINSWORTH,
C.B., D.S.O., O.B.E., M.R.C.S., D.P.H.,
Major-General, A.M.S. (ret.)

We record with great regret the death on January 27th, in his 77th year, of Major-General Sir Ralph Ainsworth, formerly Commandant and Director of Studies, and Professor of Hygiene at the Royal Army Medical College. He qualified at St. George's Hospital in 1899 and started his medical career as Surgeon-Lieutenant, R.N., but transferred to the R.A.M.C. in 1902. He took his D.P.H. in 1907, marking the start of a long connection with hygiene and public health in the Service and outside. After distinguished service in India and, in the first war, in France, when he won the D.S.O. after three mentions in dispatches, Sir Ralph was appointed Professor of Hygiene at the R.A.M. College in 1928, and became Commandant and Director of Studies in 1930. He was appointed C.B. on his retirement from the same post in 1935. He next became Director of Medical Services of the joint war organisation of the British Red Cross Society and Order of St. John and his good work in that capacity during World War II was rewarded with a knighthood in 1946.

Sir Ralph had been a Fellow of the Society since 1920 and will be well remembered by many members, particularly in the Services Group and the Metropolitan Branch. He also attended several annual dinners. He did much, with his charming personality and lifelong interest in preventive medicine, to bring together the public health elements in the Army and in civil life. We express sincere sympathy to his widow, his two daughters, and his son-in-law, Lieut.-Colonel E. F. W. Mackenzie.

BOOK REVIEWS

Directory of Collections of Micro-organisms and List of Species maintained in the United Kingdom and the Crown Colonies. London: H.M. Stationery Office. Price 5s., by post 5s. 3d.

A directory of collections of micro-organisms maintained in the British Commonwealth and a list of species obtainable from them has been prepared by the Department of Scientific and Industrial Research and is now published. Details of 91 collec-

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tions are given, with the types of organisms held and whether they can be obtained on request, on payment of a fee, or as a personal favour. The list of species is divided into sections corresponding to the different branches of micro-biology and includes algae and protozoa, bacteria, fungi, viruses and bacteriophages and yeasts.

Opposite each species name there are the code numbers of collections maintaining the organism, from which full particulars can be found.

The Practice of Sanitation. By EDWARD S. HOPKINS and FRANCIS B. ELDER. (Pp. viii + 424, 110 figs. Price 60s. net.) London: Bailliere, Tindall & Cox. 1951.

The authors, Edward S. Hopkins, Principal Associate Engineer, Bureau of Water Supply, Baltimore, and Francis B. Elder, Engineering Associate, American Public Health Association, are both senior officers of the Medical Service Corps (Sanitary Engineering Section), United States Army Reserve.

They endeavour, in this somewhat slim volume, to bring together the pertinent facts comprising sanitation practice as it is to-day in the United States of America.

The uneven development in the U.S.A. of what may be regarded as essential public health amenities is apparent from the chapters on water supplies and disposal of sewage. Of course, the water supply problems of the State of Nevada—mean annual rainfall 8·99 inches—must require a different solution from the supply problems in the State of Carolina—mean annual rainfall 63·00 inches. It is something of a surprise to read that 14,581,440 dwellings in the U.S.A. (representing an estimated population of 60 millions) are using individual sewage disposal methods; and further, that 846,148 dwellings have no toilet or privy.

The authors are insistent on the use of the term "Disinfection" in regard to the control of pathogens in water supplies, food production, milk control, etc. They maintain that the more commonly used term "sterilisation" is a misnomer and should not be used except when all forms of life are destroyed.

"Sanitising" is a term that has, apparently, come into use in the U.S.A. Its basic meaning is "to render sanitary." It implies rendering an article clean of any aesthetically objectionable material, plus elimination of any harmful contamination. It indicates cleaning and bactericidal treatment.

In the absence of a chapter dealing with the matter of Public Health legislation, it is difficult to estimate from the text what legislation exists and by whom it is administered. It is obvious, though, that types of local government differ and may be a mayor and council or a city manager. It would appear that a sanitary survey of any area may be ordered by the State Department of Health and the authors detail the general information to be obtained and reported. It is suggested that in the report on the form of local government, notes should be made of the use of merit systems for employees' procurement and control, and interference by politicians in administrative actions.

Complete accord can be voiced in regard to the authors' last sub-paragraph, Legal Enforcement: "Any health department that has a large number of Court actions is admitting its inability to meet the responsibilities of the department without using the arm of the law. Resort to Court action is an admission of failure to sell the programme to the community."

R.S.I. PRIZE ESSAY COMPETITIONS, 1952

The Council of the Royal Sanitary Institute announce that prizes are offered during 1952 for the following open competitions.

THE HENRY SAXON SNELL PRIZE.—This prize was founded to encourage improvements in the construction or adaptation of sanitary appliances, and is to be awarded by the Council of the Royal Sanitary Institute at intervals of three years, the funds being provided by the legacy left by the late Henry Saxon Snell (Fellow of the Institute).

The prize in 1952 will consist of 50 guineas, and is offered for an essay on "The Selection, Utilisation and Hygienic Operation of Equipment for Cleansing Utensils, Crockery, etc., in Hotels, Restaurants and Canteens."

THE JOHN EDWARD WORTH PRIZE.—Under the terms of this bequest the Council have, at their discretion, to award prizes to students of domestic sanitary science, or they may use the income from the fund for promoting a knowledge of that science or the encouragement of any practical improvement of appliances or inventions used or proposed to be used in or about dwelling-houses. The funds are provided by a legacy left by the late John Edward Worth (Fellow of the Institute).

For 1952 the Council have decided to offer a prize of £40 for an essay on "The Design, Construction and Fitting of Prefabricated Units for Cold and Hot Water Supplies and Waste Disposal in Hojsing Schemes."

THE JOHN S. OWENS PRIZE.—Under the terms of this bequest the Council of the Institute has to endow an annual medal or prize for theb est paper on the subject of atmospheric pollution of dwellings and its effect upon human health, the funds being provided by the legacy left by the late John S. Owens (Fellow of the Institute).

The prize in 1952 will consist of £15, and is offered for an essay on "The Ventilation of Buildings used for Industrial Processes giving rise to Noxious or Unpleasant Dusts and Fumes, and the Prevention of Atmospheric Pollution by such Dusts and Fumes." Essays should be limited to selected industrial processes.

General Conditions applicable to each Competition

1. The competitions are open to any person.

2. Essays can be submitted for more than one competition by the same person.

3. Competitors may combine in sending in an essay.

4. Each essay must be typewritten on foolscap paper and must not have been previously published. Any illustrations accompanying the essay must be prepared in accordance with the Institute's "Instructions to Authors," a copy of which will be supplied on request.

5. Essays must be delivered on or before December 31st, 1952, addressed to the Secretary of the Royal Sanitary Institute, 90, Buckingham Palace Road, London, S.W.1.

6. The essay must be submitted without the name of the competitor.

7. Each essay must bear a *nom de plume*, legibly marked on the right-hand lower angle of the first sheet.

8. Each essay must be enclosed in an envelope, bearing the title of the competition, *e.g.*, "Henry Saxon Snell Prize," "John Edward Worth Prize" or "John S. Owens Prize," and the competitor's *nom de plume* at the lower right-hand corner.

9. Each essay must be accompanied by a letter containing the *nom de plume* and the competitor's name and address, in a sealed separate envelope, having on the outside the name of the competition and the same *nom de plume* as that attached to the essay submitted.

10. Should none of the essays be considered of sufficient merit or importance to deserve the prizes offered, the Council reserve the right of withholding any of the awards.

11. In the event of two essays for any competition being of equal merit, the prize may be divided.

12. The essays for which the prizes are awarded will become the property of the Institute. Should the Council decide to publish any essay, notice will be given to the competitor.

13. The carriage of essays to and from the office of the Institute, and all expenses incidental thereto, must be paid by the competitiors. Unsuccessful essays will be returned on application, on the production of a formal demand within a period to be specified after the close of the competitions.

14. Due care will be taken of all essays, but the Institute will not be responsible for any loss of, or damage to, them hwile they remain in its keeping.

J. W. DUDLEY ROBINSON,
Secretary.

90, Buckingham Palace Road,
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January, 1952.

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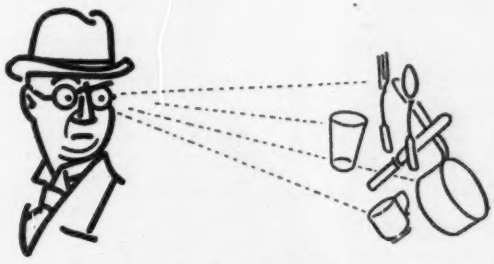

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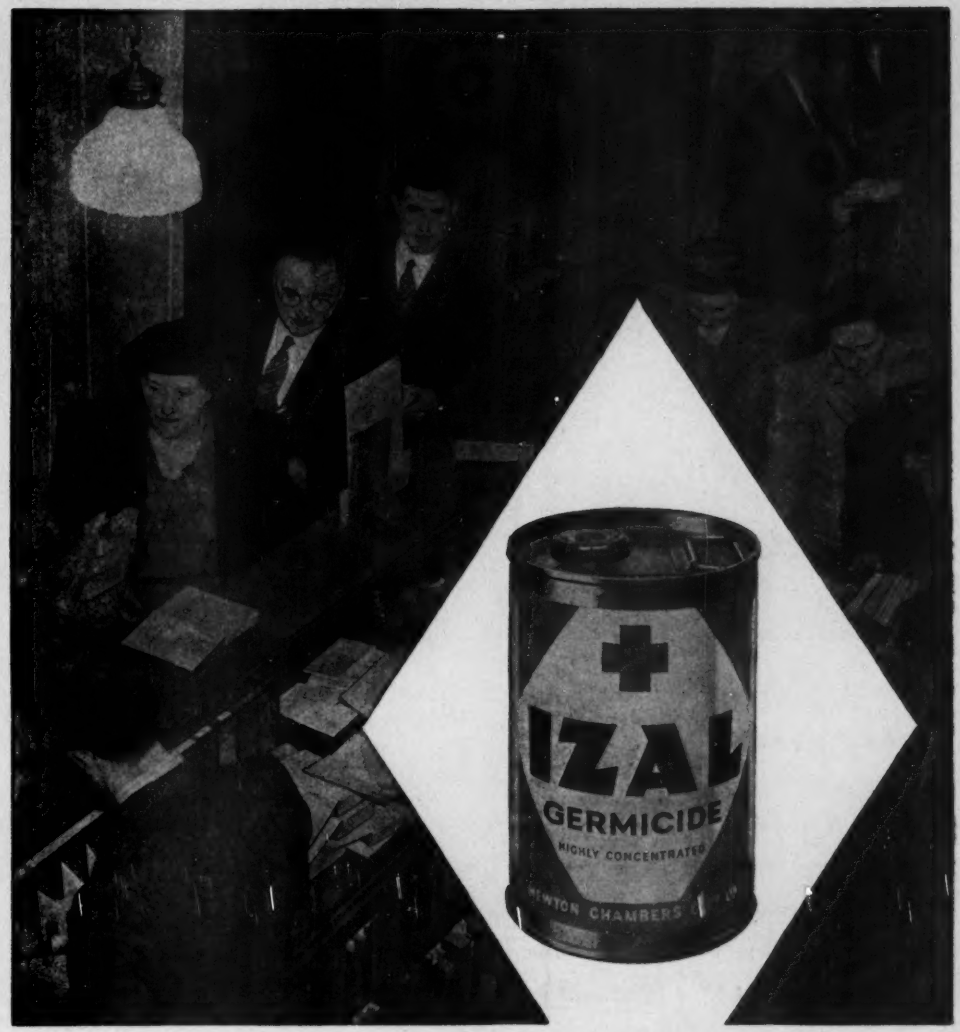

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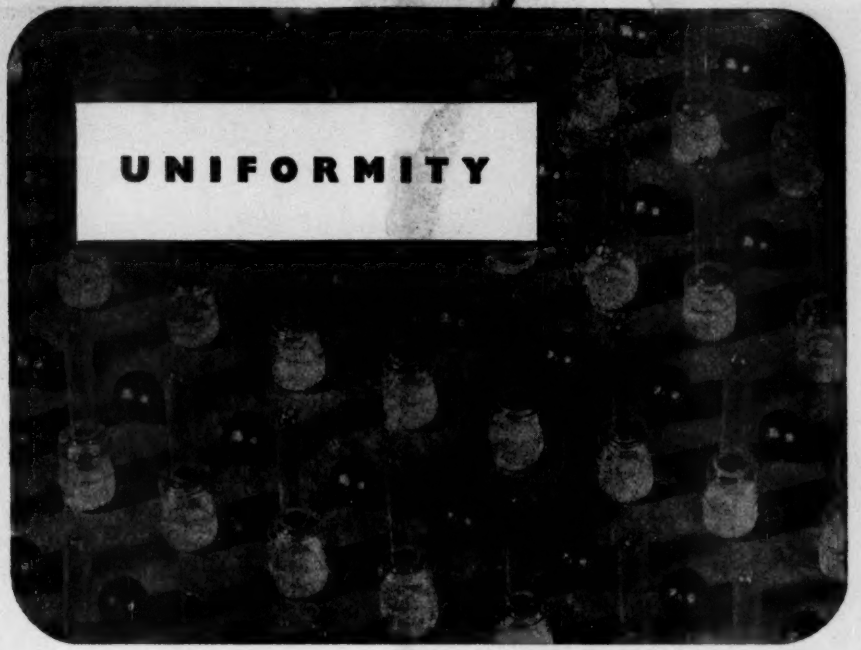

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